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BULLETIN

OF THE

AMERICAN COLLEGE of SURGEONS

VOL. IX JULY, 1925 NO. 2

PUBLISHED QUARTERLY BY THE
AMERICAN COLLEGE OF SURGEONS
40 EAST ERIE STREET :: :: CHICAGO

STORAGE

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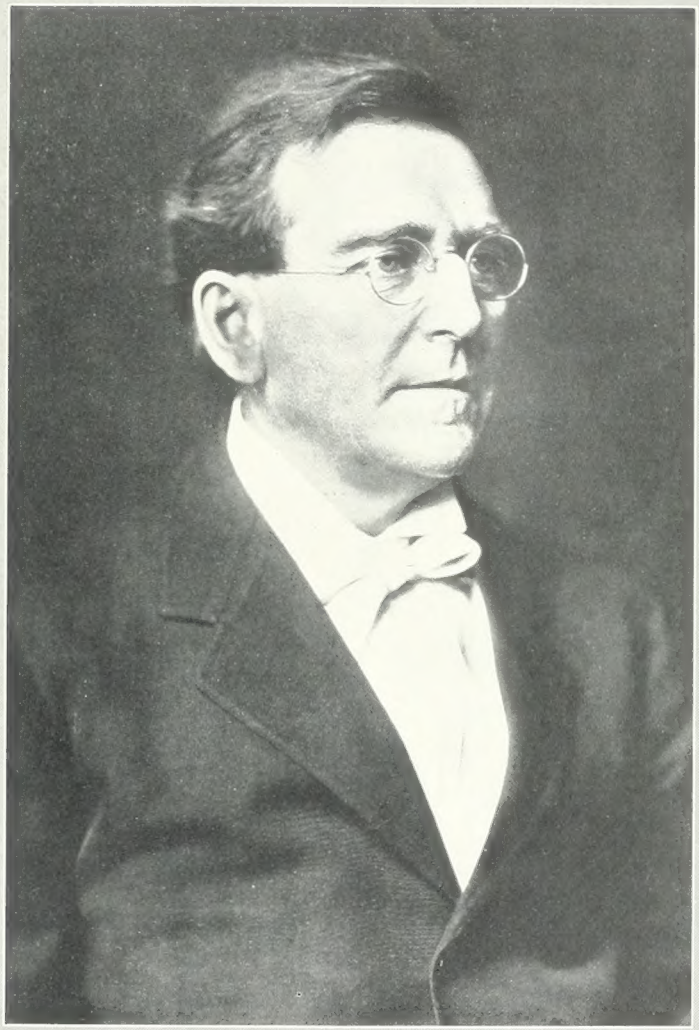
In Memoriam

EARLY Saturday morning, July 25, Dr. Albert J. Ochsner of Chicago passed away. His death was due to coronary thrombosis.

For many years Dr. Ochsner has been one of the outstanding surgeons of America. His influence in the broad field of scientific medicine will remain as a fitting memorial to a great man. The world can ill afford to lose such a character whose sound judgment and practical experience were ever at the disposal of those who sought his advice. Each Fellow of the American College of Surgeons has lost a friend. Dr. Ochsner was one of the founders of the College, a Regent, and then President.

He was laid away in a little cemetery amongst his native hills at Honey Creek, Wisconsin. There he rests under the whispering pine trees whilst the world moves on bearing the memory and influence of a great surgeon, a noble character, and a true friend—on into the distant future when young men may mould their lives according to his fashion.

To Mrs. Ochsner and his family we extend our deepest sympathies. With them we join in deep sorrow for a loss which is beyond our expression.



ALBERT JOHN OCHSNER, M.D.

EX-PRESIDENT AND REGENT, AMERICAN COLLEGE OF SURGEONS

BORN APRIL 3, 1858 — DIED JULY 25, 1925

THE SELECTION OF CANDIDATES FOR FELLOWSHIP

THE excellent attendance at the meetings of the various Credentials Committees and the increased personal interest which the Committee members have been giving to the selection of candidates for Fellowship is a very healthy sign and one which has greatly pleased the Board of Regents and management of the College.

In order that there may be a definite understanding of the method of conducting Credentials Committee Meetings and the thoroughness with which the names of candidates are considered, the following is an outline of the instructions presented at each Credentials Committee Meeting:

(1) The American College of Surgeons is desirous of having the good men in the profession of surgery as Fellows, but does not desire those who are professionally or otherwise unfit.

(2) There is a serious responsibility placed upon the members of the Credentials Committee because of the fact that no candidate can go further with his Fellowship until he receives the approval of his State or Provincial Committee. Each candidate should be known to at least some members of the Committee. If he is not known, then one or two members of the Credentials Committee should be authorized to look him up and make a report to the Central Office for presentation at the next meeting of the local committee.

(3) The Chairman should appoint from amongst the members of the Committee someone to act as Secretary to keep a record of the proceedings of the meeting. A copy of this record is to be forwarded to the American College of Surgeons in Chicago as soon as possible after the meeting.

(4) The proceedings of the Credentials Committees are confidential and what takes place concerning the discussion of the eligibility of a candidate for Fellowship is not to be repeated outside the meeting.

(5) The qualifications of candidates for Fellowship in the American College of Surgeons may be regarded by the members of the Committee under three heads:

(a) Moral and ethical character. Is he a man of sound moral principles and good character who, having taken an oath and declaration, will abide by it?
(b) Professional training. What educational foundation has the candidate?
(c) Professional ability. Is he a good, safe, competent surgeon?

(6) The Credentials Committee may take the following action concerning the candidate:

(a) He may be ACCEPTED for Fellowship in the American College of Surgeons, which means that he will be required to furnish one hundred case records. (Fifty major cases in detail and a résumé of fifty others.) These records are placed before the Central Examining Board for consideration.
(b) The candidate may be POSTPONED for one or two years or more for additional information or for further development in his professional career.
(c) The candidate may be considered as NOT ACCEPTABLE for Fellowship in the American College of Surgeons. Should the candidate re-apply, or should means be taken to have his name reconsidered, his application will not be brought back to the local Credentials Committee for further consideration within a period of three years unless by special recommendation of the Central Executive Committee of the College.

(7) All candidates for Fellowship in the American College of Surgeons whose applications were filed after January 1, 1923, are required to submit their case records.

(8) An exception may be made to the above ruling in the case of an outstanding surgeon of mature years who receives the unanimous recommendation from the State or Provincial Credentials Committees to the Board of Regents for special consideration. These are exceptional cases.

(9) Surgical Ophthalmologists who have passed the American Board for Ophthalmic Examinations may not be required to furnish case records as this examination is accepted by the Board of Regents in lieu of such records.

(10) Obstetricians, Ophthalmologists, Oto-Laryngologists, Proctologists, and Urologists are not accepted for Fellowship as a class, but rather as individuals. For example, a Urologist might simply be treating venereal diseases, or an

Ophthalmologist might be only fitting glasses. If these men are considered as individuals by the local Credentials Committee to be doing the surgical work incident to their specialty they may be recommended for Fellowship in the College.

(11) The names appearing on the Junior Candidate list are not to be considered for Fellowship, but rather for enrollment in the Junior Candidate Group. These young men are not in any sense to be considered as members of the College until sufficient time has elapsed and they have produced their records and met all the requirements for Fellowship. These names will be brought back to the State or Provincial Credentials Committees each year for review.

(12) Candidates who are putting in case records for consideration by the Examining Board are required to do so as early as possible so as to avoid congestion of the work of the Central Examining Committee late in the year. All case records are carefully checked and verified by the Central Office.

(13) The question frequently arises as to the amount of surgery the applicant is doing. If there is any question, the Central Office can ask him to provide a surgical list over a given period of time for the information of the various committees.

KNOW YOUR BLUE BOOK AND PLEDGE

THE annual Blue Book of the American College of Surgeons is not merely a list of Fellows of the College and approved hospitals. It contains, as well, much valuable information with which everyone interested in the College should be familiar. In the 1925 edition there are two addresses which no member can afford to miss—"The Years Between" by Dr. W. W. Chipman of Montreal, and a résumé of the intimate history of the organization and development of the American College of Surgeons by Dr. Franklin H. Martin of Chicago. These addresses will constitute an hour's delightful and profitable reading.

It is exceedingly important that each Fellow should have a thorough knowledge of the pledge of the College and particularly that part which has to do with the commercialization of medical practice and the division of fees. This part of the pledge provides a definite answer for practically all fee-splitting problems and is so plain in its statements as to be easily interpreted. It may be quoted as follows: "Moreover, I pledge myself, so far as I am able, to avoid the sins of selfishness; to shun unwarranted publicity, dishonest money-seeking, and commercialism as disgraceful to our profession; to refuse utterly all money trades with consultants, practitioners or others; to teach the patient his financial duty to the physician and to expect the practitioner to obtain his compensation directly from the patient; to make my fees commensurate with the service rendered and with the patient's rights; and to avoid discrediting my associates by taking unwarranted compensation."

It is absolutely necessary in the interests of clean surgery that every Fellow of the College should realize his personal responsibility in affording a stiff opposition to the pernicious habit of splitting fees. The College pledge is not merely a collection of high sounding words to be repeated amidst pomp and ceremony at the annual Convocation. It is a creed of honesty and integrity.

It is not sufficient that the members should ask the question, "What are they doing in Chicago about this fee-splitting problem?" It is rather more important that the stand of each individual Fellow of the College in this regard should be known and that each member, knowing the pledge, should not only live up to it, but, as well, place his strong moral support behind its principles. One cannot urge too strongly the necessity of every member of the American College of Surgeons knowing the pledge of the College intimately.

The College does not pretend to dictate the intimate details of the professional life of its members, but sets up a moral principle to which each Fellow of the College has subscribed and up to which he is expected to live. Much has been accomplished with relation to the fee-splitting situation on this continent but the individual support of every Fellow of the College in his office or hospital environment is required for ultimate success.

MEETING OF THE BOARD OF REGENTS

A MEETING of the Board of Regents of the American College of Surgeons was held at the Willard Hotel in Washington, D. C. on May 7, 1925.

In the absence of Dr. Charles H. Mayo, who was in Europe, Dr. George W. Crile of Cleveland presided. There were thirteen present at the meeting.

Reports were presented from the Departments of Hospital Standardization, Sectional Meetings, Literary Research, and the Murphy Memorial. The Treasurer presented the financial report for the year to date, and following the routine business, plans were discussed for the coming Clinical Congress, to be held in Philadelphia beginning October 26.

Doctor Albert J. Ochsner of Chicago introduced a motion requesting each Fellow of the College to present a copy of all books he has published to the College Library. This motion was seconded and carried.

The resignation of Dr. E. A. Codman of Boston as Chairman of the Committee on Registry of Bone Sarcoma was accepted with regret. On account of Dr. Codman's very valuable services as Chairman of this Committee, it was moved that a letter be forwarded to him expressing the appreciation and thanks of the Board of Regents.

HOSPITAL STANDARDIZATION PROGRAM OF THE AMERICAN COLLEGE OF SURGEONS, PRESENTED AT THE THIRD PAN AMERICAN SCIENTIFIC CONGRESS HELD IN LIMA, PERU

DOCTOR JAMES T. CASE of Battle Creek, Michigan, who was spending part of last winter in South America, represented the American College of Surgeons at the Third Pan American Scientific Congress held in Lima, Peru. Doctor Case gave an address before the Medical Section of the Congress on "The Standardization and Betterment of Hospitals." This address brought forth a considerable amount of valuable discussion and a motion was introduced by Doctor Iribarne of the Faculty of Medicine, Buenos Aires, that the scheme of Hospital Standardization as described by Doctor Case and established by the American College of Surgeons in the United States and Canada should have the appreciation of the Medical Section of the Scientific Congress and that the Congress, as a whole, should give a vote of approval and request all the Governments represented to set in motion means for accomplishing a similar work. This motion was unanimously carried, and gives evidence of a rapidly growing interest in Hospital Standardization in the South American countries.

Following Doctor Case's return, letters were received at the College from the Minister of Exterior Relations of Peru and the Secretary General of the Congress expressing their appreciation of Doctor Case's visit to Lima and their interest in the work of the American College of Surgeons.

The thanks of the College are due to Doctor Case for the able way in which he represented the organization at the Scientific Congress.

CONFERENCE WITH THE AMERICAN COLLEGE OF PHYSICIANS

AT a meeting of the Executive Committee of the American College of Surgeons held on January 4, the President, Dr. Charles H. Mayo, and Dr. Allan Craig were delegated to attend the Washington meeting of the Clinical Congress of Internal Medicine and represent the College of Surgeons at the meeting of the Board of Regents of the American College of Physicians.

On March 9, Dr. Mayo and Dr. Craig went to Washington and were accorded a very cordial reception by the physicians. The principles of Hospital Standardization and the Junior Candidate Group idea were placed before the Regents of the College of Physicians. It was definitely pointed out that Hospital Standardization was not intended for the surgeons alone, but is a broad movement affecting as well the internist, the laboratory man, and everyone connected with hospital service. It was also shown that the Junior Candidates plan would only reach its ultimate success when such an opportunity was made available for the young man in the field of internal medicine. The question of fee division and commercialized practice was also discussed and the

necessity of complete co-operation between the internist and the surgeon in combating this professional menace was pointed out.

The Board of Regents of the American College of Physicians was unanimous in its approval of the stand of the American College of Surgeons and expressed itself as desirous of co-operating in every way. The President of the College of Surgeons invited the Regents of the College of Physicians to appoint two representatives to attend a meeting of the Regents of the American College of Surgeons for the purpose of further advancing co-operative relations between these two bodies. The delightful reception given the representatives of the American College of Surgeons while at the Washington Meeting of the American College of Physicians was deeply appreciated.

SECTIONAL MEETINGS

SINCE the first of January, 1925, eleven Sectional Meetings of the American College of Surgeons have been held as scheduled in the following table:

[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]
Arkansas, Kansas, Oklahoma, Missouri	Little Rock	February 10–11
Alabama, Georgia, Florida, Louisiana, Mississippi	Mobile	February 13–14
[illegible]	[illegible]	[illegible]
Indiana, Ohio	Indianapolis	February 19–20
South Carolina, North Carolina	Charleston, S. C.	March 16–17
West Virginia, Virginia, Maryland, District of Columbia	Charleston, W. Va.	March 20–21
Pennsylvania, New Jersey, Delaware	Scranton	March 23–24
New England States	New Haven	March 26–27

The visiting speakers at these meetings were as follows: Drs. George W. Crile, Cleveland, Ohio; Franklin H. Martin, Chicago, Illinois; Hugh Cabot, Ann Arbor, Michigan; Alfred W. Adson, Rochester, Minnesota; Edward Jackson, Denver, Colorado; William Carpenter MacCarty, Rochester, Minnesota; Vilray P. Blair, St. Louis, Missouri; J. Garland Sherrill, Louisville, Kentucky; Haven Emerson, New York City; Basil Graves, London, England; Robert Greenough, Boston, Massachusetts; John B. Deaver, Philadelphia, Pennsylvania; Rev. C. B. Moulinier, S. J., Milwaukee, Wisconsin; Mr. Robert Jolly, Houston, Texas; Rev. Newton Davis, Chicago, Illinois; Rev. J. A. Diekmann, Cincinnati, Ohio; Malcolm T. MacEachern, Chicago, Illinois; and Allan Craig, Chicago, Illinois.

The moving picture film entitled, "How the Fires of the Body are Fed," produced by the Carpenter-Goldman Laboratories in New York and released through the Pictorial Clubs, Inc., has been utilized this year by the College in connection with the public meetings. This film has attracted a great deal of attention. It is, without doubt, the most graphic demonstration of the process of digestion and the assimilation of food which has ever been used for the education of the public along medical lines. The thought and efforts of Messrs. Goldman and Carpenter in the production of this excellent film are worthy of our consideration. They are now working upon a similar demonstration of the process of respiration which, it is hoped, will be available for the Sectional Meetings of the College of Surgeons next year.

The attendance at the public meetings in the various centers where Sectional Meetings were held far exceeded our fondest expectations. In many places the largest auditoriums available were insufficient to accommodate the audience, and in one or two locations it was necessary to use two auditoriums on the same night. There is no doubt in our minds but that the public is keenly interested in health and scientific medicine.

Representatives of the American College of Physicians were present at a number of the Sectional Meetings this year and took part in the programs. The attending physicians were as follows: Frank Smithies, Chicago, Illinois; Frederick Epplen, Spokane, Washington; Frank Pottenger, Monrovia, California; George M. Eckel, Hot Springs, Arkansas; James F. Churchill, San Diego, California; John M. Blackford, Seattle, Washington; Lee W. Roe, Mobile, Alabama; Charles G. Lucas, Louisville, Kentucky; William A. Jenkins, Louisville, Kentucky; Stewart R. Roberts, Atlanta, Georgia; J. N. Simpson, Morgantown, West Virginia; John Lichty, Clifton Springs, New York.

THE COLLEGE LIBRARY

THE Library of the College and the associated Department of Literary Research occupy the upper floor of the new building. The stack room is now equipped with one tier of book stacks and there is room for two other decks to be installed as needed. The collection of books already on hand, which is largely made up of contributions from Fellows of the College, is now being assembled on these shelves and classified for use. It was necessary for a time to stop receiving additional contributions as there was no available space for storage. It has been necessary also to sort and list the books on hand so as to avoid, as far as possible, duplication and reduplication in the collection. We now are in a position to add to our library. We would greatly appreciate it if persons who are ready to send in large or small collections of books would first furnish us with lists. These lists will be checked with our present collection and the donor notified as promptly as possible of the books which are needed in the library.

We are also interested in unbound journals and reprints. If the journals are not needed to complete sets of bound journals, good use will be made of them in adding to the file of loan material in the Package Library maintained by the College for its Fellows. We would like to have at least two copies of all reprints, one for a permanent file of the works of the Fellows of the College and the other for the loan file.

We are very grateful for the hearty co-operation given to the College Library by the Fellows and hope with their support to continue to expand in order to keep up with the opportunities for service.

RESEARCH WORK IN THE COLLEGE LIBRARY

SINCE the October meeting of the College, at which time a brief report was given of the work of the Department of Literary Research, there have been prepared and sent out over three hundred pieces of research work consisting of bibliographies, abstracts, and translations of medical and surgical literature. These have gone to Fellows of the College in the United States, Canada, South America, Australia, Korea, England, Sweden, and South Africa.

The Department now has seven subjects of continuous research work. In each case a report has been made of the literature over a number of years and then the request has been received to continue the research work by keeping up with the current literature and reporting at intervals on the newer phases of the subject.

Requests for research work are usually fewer in number during the summer months, but the Department now has considerable work on hand. This is a great advantage to us and to the doctors using the service. Better work can be done if the requests are received far in advance of the need for the finished material, reducing to a minimum the number of emergency requests just before the Fall meetings.

How to Make Requests for This Service.

That can be told briefly by saying, "Write the Department just as you would instruct some one in your office." You would not tell an assistant in your office to get you some material on appendicitis or intestinal obstruction; yet the Department receives requests just as general and unlimited as that.

We should be glad to have you tell us the nature of the case you wish to report or to have a brief outline of the phases of the subject in which you are interested. Indicate whether you wish a comprehensive review or are interested only in the recent literature on the subject. If you list the journals to which you have access, references to these journals will be sent so that you may do some reading from the original while abstracts of additional articles are being prepared in the Department.

The Library and Department of Literary Research have been moved. They now occupy the upper floor of the Murphy Memorial Building. While only a part of our new equipment is installed we have better facilities for carrying on this work than ever before. Among other things we now have shelf room for expanding our file of classified material in our Package Library. This collection of reprints and clippings from journals makes it possible to maintain a loan service without charge to the Fellows of the College. Its greatest use is in connection with our research service where a file of articles on a specific subject is sent out accompanied by the abstracts and translations of additional articles prepared with the doctor's instructions in mind.

STAFF CONFERENCE DEMONSTRATION

By the Combined Staffs of St. Catherine's and Greenpoint Hospitals, Brooklyn, N. Y.

Directed by FRANK D. JENNINGS, M.D., F.A.C.S., Brooklyn

Frank D. Jennings, M.D., *Chairman*,

Mr. President, Fellows of the College, Ladies and Gentlemen:

This is to be a demonstration of a Staff Conference tendered to you by the combined staffs of St. Catherine's and Greenpoint Hospitals, both in Brooklyn.

St. Catherine's is a parish hospital, owned by the parish of the Most Holy Trinity Church, and is in charge of the Sisters of St. Dominic. The Greenpoint is one of a group of hospitals in the Department of Public Welfare, the Commissioner of which is the Hon. Bird S. Coler. These hospitals are situated within a few blocks of each other and are served by staffs composed, in many instances, of the same men. Their bed capacity is between five and six hundred, and their admissions are about ten thousand annually.

The plan of hospital organization, insofar as medical and surgical affairs are concerned, is much the same. That is, there is a Medical Board which is charged with the responsibility and care of the medical and surgical matters of the hospital responsible in the one instance to the Medical Board and in the other to the Commissioner.

Each Board has various committees, such as executive, interne, dispensary, training school, etc., to expedite the handling of work. Included among these is one known as the Staff Conference Committee. This committee is composed of a chairman and two other members, representing, usually, major services. The duty of this committee is to prepare the agenda for the meetings and full authority is given it to select any record for presentation, be the patient private or one from the general service. Any record selected must be presented by the physician who was in charge of that patient. It is absolutely essential that the committee have such authority.

Shortly before the end of the month the committee goes to the record room, where the record room keeper has grouped the records for their perusal and study. Generally they are of patients who have died, been discharged unimproved, or of those showing unusual morbidity. Having decided upon the records to be presented, they are set aside. The record room keeper, in sending out the notice cards of the meeting, rubber-stamps those going to the men who are to report. This stamp states: "You will be called upon to report on your case. Kindly abstract the record." It may be mentioned here that when the committee selects the record it also designates for each record a record critic, whose card of notice also carries a stamped statement to that effect. The duties of the record critic will be described later. A typewritten list of the case numbers, the names of the doctors to present the cases, the diagnoses of the cases, and the names of the record critics is posted on the bulletin board of the staff room several days in advance of the meeting. This is signed by the chairman of the committee. No changes may be made in the records for presentation after their selection by the committee.

The staff meetings are held once a month, from October to June, on fixed evenings, at specified times, at St. Catherine's on the first Monday, at 9:30, at the Greenpoint on the third Thursday, at the same hour. Experience has proven that to be the most convenient time for the greatest number of men.

To conduct conferences properly certain "props" are necessary. First, a table for the chairman and secretary of the meeting. The latter is usually one of the younger men of the staff. He takes charge of the records, assigning them to the record critics and collecting them after the meeting, keeps the minutes, i.e., makes a record of the cases presented, by whom reported and discussed, and either marks those present or passes an attendance book which is signed by everyone who attends. Second, a pulpit or reading stand, over which should be a light so that the reader may easily see his manuscript, is advantageous. Third, a blackboard; fourth, light boxes for showing x-ray pictures; and fifth, a stereopticon with screen—are all necessary.

The meetings start promptly and are conducted with dignity and characterized by frankness and fairness. Presentation of the history abstract is usually limited to five minutes, and discussion to ten. This rule cannot be arbitrarily followed but it is a good basis on which to start. A two-hour meeting thus allows the presentation of eight reports.

At the opening of the conference an analysis of the previous month's work is presented, at St.

Catherine's on a blackboard, at the Greenpoint by typewritten forms, which are passed about. The data compiled are the same at both hospitals. Included are the total number of admissions and discharges, classified as to recovered, improved, unimproved, transferred, refused treatment, to return, died, and incomplete; the number of deaths, twenty-four hour, forty-eight hour, and those above that time, classified as to medical; obstetrical (a) mother, (b) child; surgical, operative and non-operative; operations, divided into general surgery, special surgery (gynæcology, urology, ophthalmology, etc.); the number of deliveries, including normal, forceps, breech, version, cesarean section; x-ray department, giving total number of treatments; total number of autopsies; consultations, number requested and number granted, classified according to the various services; total number of unimproved patients with the diagnosis, wound history, giving total number of operations, closed tight or drained, with number of wound infections; outpatient department, giving total new visits and re-visits. It is statistical and dry, as statistical things are apt to be, but it is important, as there is afforded in this way a brief review of the work of the hospital, which is timely and of intimate interest for the staff. It is obvious that the staff must be interested in the percentage of wound infections, the number of autopsies, the death rate. The record room is assuredly interested in getting before the staff the number of incomplete records. Records are not filed until completed, and a stimulus is given the staff members to complete their records by seeing each month the total number waiting to be filed.

After consideration of the monthly analysis the conference opens. Just a word here as to the functions of the record critic. It will be recalled that in presenting a case it must be abstracted. This, of necessity, demands "boiling down" the record, often difficult in a lengthy case. The critic holds the record during its presentation and answers questions arising which the abstract cannot. He sees to it that the abstract does not contain anything which is not in the record, and when discussion on the case is finished he closes "on the record," pointing out its faults or excellencies, as the case may be.

Now that we have indicated to you briefly the machinery by which the conference is created, we will declare the staff meeting of Monday, October 20th, opened.

The first case report is one of retained placenta, secondary anemia, septicemia, transfusion, embolism, death.

DOCTOR————

Female, age 28, married.

Admitted: 9/20/20. Died: 10/8/20. Total time in hospital 18 days.

Admission diagnosis: Pregnancy; Mild Toxemia.

Working diagnosis: Pregnancy O.L.A. Parturition O.L.A.

Complications: 1. Retained secundines. 2. Embolism of pulmonary artery (puerperium).

History: She had four pregnancies, all normal, with normal puerperium. Miscarriages, none. First day of last period December 19, 1919.

Physical examination on admission: Fetal presentation cephalic in type. Position O.L.A., fetal heart being best heard in left lower quadrant. Her pelvic measurements showed,

Interspinous	24 cm.
Intercrestal	26 cm.
Right oblique	21 cm.
Left oblique	20 cm.
External conjugate	20 cm.
Bi-ischial	10 cm.

Systolic murmur noted at apex of heart.

Sibilant and sonorous râles over both sides of chest.

Blood pressure 120/65.

Delivered: 9/24/20. Delivery uneventful, except fetus had one coil of cord around its neck, which was easily removed.

There was moderate postpartum hemorrhage. There were no lacerations. The placenta was retained. Total duration of labor four hours and twenty minutes.

General condition on leaving table, good.

Follow-up notes, between 9/25/20 and 9/30/20: Lochia was foul. Repeated attempts were made to express placenta by means of Credé method.

On 10/1/20 under aseptic precautions attempt was made to remove part of placenta thought to be in the vagina. Several pieces of placenta were removed from vagina. Gas was noted in vaginal discharge. Cervix was found extremely soft, moderately dilated. Uterine walls very thin. No attempt was made to remove placenta from uterus. The following day patient seemed better.

On 10/4/20 blood count was made, as follows: Sahli hgb. 40; W.B.C. 15,000; Polys. 80. Small and large lymph. 20%.

On 10/7/20 patient complained of pain in left leg. Phlebitis was suspected though not evident.

On 10/8/20 a donor was secured and found to be in group 2, the same as the patient. On that morning patient was transfused by citrate method, 430 c.c. (blood and citrate mixed) being given by gravity method. Time 25 minutes.

At 11 A.M. that morning, on her return to the ward, patient had chill which lasted twenty to thirty minutes. After chill she complained of rapid heart action.

At 1:15 P.M. patient had severe pain in chest, became pale, was covered with profuse sweat, complained of thirst, gasped for air, and finally died at 1:35 P.M. This was two hours and thirty-five minutes after her return to the ward.

On admission her temperature was 98.3 and her pulse 100. They remained approximately so for the first five days' stay in hospital. Her temperature varied from 99 to $103^{2}/_{5}$, and her pulse ran from 90 to 140. There were two urinary examinations made on this case; the first negative, the second showing a faint trace of albumin and a few granular casts.

CHAIRMAN: The case is now before you for discussion, gentlemen, comment or criticism.

DOCTOR —— Mr. Chairman, here we have an extremely interesting case, one that brings up or renews that old controversy. Before we go any further, doctor, possibly you might tell me what is meant by a "mild toxemia."

RESPONSE: That was the interne's impression at the time of admission. It was not borne out by the clinical facts in the case.

DOCTOR —— This was, as I understand it, an absolutely normal delivery.

RESPONSE: Absolutely; L. O. A., without interference.

DOCTOR —— Do you know of the prenatal care?

RESPONSE: I know absolutely nothing of her prenatal care.

DOCTOR —— Then, if I understand it correctly, the signs of infection did not show up until five days after delivery.

RESPONSE: I am not sure as to the exact time. She was in the hospital five days before she was delivered.

DOCTOR —— Can you tell me now when the temperature first rose?

RESPONSE: I think within about twenty-four hours after delivery; that was my impression. The record critic can tell you exactly.

DOCTOR —— I presume by the fact that she entered the hospital five days prior to her delivery that she was instructed to go there by a competent physician, or probably through the dispensary, and that she had her prenatal care in the dispensary. Her delivery was spontaneous; there were no lacerations; no vaginal examinations, no man-handling, but she had a retained placenta. The question now is, whether to remove it or whether to leave it alone. And can you, or possibly some of our members here, tell me the bacteriology of a placenta under those conditions left in the uterus for one, two weeks, or, as we have known, longer, communicating through to the air, through a patulous cervix, a cervix in which are imbedded, as we all presume, pathologic organisms, lethargic but easily excited to activity by the trauma incident to the labor—can you now tell me if that placenta becomes infected? I think that is the crux of the argument. If the sepsis develops spontaneously, then the placenta should be removed from the uterus before decomposition and bacteriological changes take place.

CHAIRMAN: Your question then, doctor, I take it, is whether or not, in the speaker's opinion, more prompt removal of the placenta might have prevented the infection?

DOCTOR —— Exactly.

RESPONSE: I think not.

CHAIRMAN: He thinks not.

DOCTOR —— Mr. Chairman, I do not think that is the question so much as whether there was an indication to remove the placenta. If I am not mistaken, about eight days after the delivery the doctor has a blood count done and it discloses 2,800,000 reds. Is that right?

RESPONSE: That is right.

DOCTOR —— Was there a blood count done before that?

RESPONSE: There was not.

DOCTOR —— Is it fair to presume that the patient came into the hospital with a normal blood count? She must have had a hemorrhage because of the high red blood count.

RESPONSE: Moderate hemorrhage is recorded on the record sheet.

DOCTOR —— Then, Mr. Chairman, I think she must have had a hemorrhage at some time during the delivery that he was not aware of. I think the nurse's record ought to show that.

DOCTOR —— The record states that she had a moderate amount of hemorrhage, and the lochia the doctor stated was not abnormal in any way.

DOCTOR —— Mr. Chairman, does "postpartum hemorrhage" mean postpartum bleeding? As I understand, it is customary to leave the placenta in if there is no hemorrhage. Is hemorrhage in this relation to be considered as ordinary bleeding postpartum?

RESPONSE: The hemorrhage spoken of in this case has reference to the hemorrhage which occurred at the time of delivery and not to any subsequent time we know of.

DOCTOR —— The cause of death had nothing to do with hemorrhage, unless we believe that the woman shot a sudden embolus. In view of the fact that the vaginal secretion is noted as having been foul and that gas was there, is it not very likely this woman had a bacillus aërogenes capsulatus bacteriological infection, resulting in embolism and then death?

DOCTOR —— Was a culture made?

RESPONSE: There was no culture made.

DOCTOR —— Mr. Chairman, we felt that culture of the lochia or any piece of the tissue removed from the vagina for the discovery of bacillus aërogenes capsulatus would be futile because that same organism had been discovered in the normal vagina in the normal lochia of women. We leave the placenta in because we believe that it is much more dangerous to remove it, because, in our experience, it mostly always comes away. The placenta that is partially detached will bleed, and

look out for it! Now apparently this case did bleed and apparently, in looking over the progress notes, there is no record of bleeding, but again looking through the nurse's notes a record will be found that she had profuse bleeding and several times after being returned to the ward passed large clots; so that apparently the indication for its removal was there but it was not removed. That, I believe, sums up the case. It was not a matter of infection, the infection was getting better. She went to the operating room in good condition and came back in good condition, but died from a pulmonary embolus.

DOCTOR —— I just want to corroborate a statement made by the last speaker, that the gas in the vagina does not necessarily indicate an infection.

DOCTOR —— You say the patient died two hours and a half after the transfusion. Then could the transfusion not have been the cause of death? If I understand it correctly, the patient was well until she went up for transfusion. Then it appears that something went wrong in the transfusion, because if the patient died two and a half hours after I believe it was due to the transfusion itself.

DOCTOR —— Mr. Chairman, I think the doctor's question has to be answered as not having to do with the transfusion at all. It is more likely, in view of the fact that the circulation improved after the transfusion, that there was possibly a breaking off of the clot, or it may have been due to the patient having been taken off the table and the loosening up of a clot in the femoral or iliac.

DOCTOR —— Was there any reaction after transfusion?

RESPONSE: Yes sir, there was.

DOCTOR —— The temperature was 103.1. Was that not rather a high temperature for her to be running?

CHAIRMAN: The discussion on the case is closed. The record critic will now report.

RECORD CRITIC: Mr. Chairman, most of the points relative to the deficiency in the record have been brought out in the discussion, the most important being those pertaining to blood counts. This woman had only one blood count. She should have had more. As to blood pressure, she had one taken on admission, no more. The urine examination was not frequent enough. Blood cultures from the vagina and the uterus, in the presence of sepsis, should always be made, not because this woman had gas passing from her uterus and vagina—that happens in many cases, as the doctor has stated previously. There was no record of excessive bleeding except immediately on return to the ward, when the nurse noted that there was excessive bleeding, and following that the next morning expulsion of some clots. There is no other record of any further bleeding. Furthermore, there is no date on the sheet containing the record of the operation for transfusion in our history, so that we have to go all through the history to find the date of the transfusion. The follow-up notes are good; the nurse's notes are good—I might say excellent. The diagnosis record is full enough. I should say that altogether the history, so far as the nurse's notes and the diagnostic notes are concerned, is all right, but lacking culture, record of bleeding and the date of transfusion, and is not up to the standard.

CHAIRMAN: Thank you.

The next case report is congenital malformation of kidneys and ureters in a baby, cystoscopy and death in thirty hours.

DOCTOR ——

Female baby, age 8 months.

Admitted: 3/3/24. Died: 3/9/24. Total time in hospital 6 days.

Admission diagnosis: Intra-abdominal tumor.

Working diagnosis: Pyonephrosis or Hydronephrosis (left).

History: For past five weeks mother noticed that whenever she picked up the baby or touched its abdomen the baby would cry. For the past few days child would cry when voiding, and this crying with each act of micturition became more violent. Urine had a very foul odor. The family physician discovered a tumor in abdomen and sent baby to hospital. Baby also suffered from constipation from birth and each bowel movement seemed to be painful and accompanied by much straining.

Physical examination on admission: Because of abdominal distention and spasm of abdominal muscles, due to crying, satisfactory palpation was somewhat difficult. A tumor, however, could be felt to the left of the umbilicus, cystic and somewhat movable. On 3/7/24, four days after admission, this mass seemed to be larger and urological investigation was advised. 3/8/24, cystoscopy under anæsthesia (ether).

Bladder urine very cloudy (apparently purulent).

Right half of bladder appeared normal.

Left half markedly inflamed and edematous.

Right ureteral orifice and areola normal in appearance.

Left meatus could not be located because of marked inflammation present.

Catheter passed easily up right ureter—no obstruction.

Specimen collected for examination.

During cystoscopic examination fluid in bladder became cloudy, showing that pus was probably coming from the left ureter.

Diagnosis: Left Pyonephrosis; Right Pyelitis.

Follow-up notes: 3/9/24, general condition not good, pale, pulse thready. Mass, however, was impalpable, probably having drained through ureter. Condition grew progressively worse and patient died that evening.

Laboratory data:

3/6/24 Urinalysis—few pus cells.

3/8/24 Urine from right kidney—very many pus cells. Smear—streptococci and some gram negative bacilli. Culture—B. coli.

3/4/24 Blood count—R.B.C. 3,500,000; W.B.C. 13,000; Hgb. 65%; Polys. 77; Lymphs. 23.

3/7/24 Blood count—R.B.C. 3,690,000; W.B.C. 30,000; Hgb. 59%; Polys. 94; Lymphs. 4.

X-Ray of abdomen negative.

Range of temperature 100–103; pulse 100–120; respiration 20–60.

Treatment: Fluids forced; water per rectum and by clysis; external heat; stimulants.

Autopsy.

Pathological findings: Left kidney enlarged and apparently cystic. There were two dilated ureters arising from separate pelves but joining about an inch from the bladder. Right kidney smaller than left, cystic, with two dilated ureters joining about one inch from the bladder; bladder wall thickened, suggestive of chronic inflammatory process. On opening the kidneys there were found merely large cysts with little kidney substance left.

Anatomical diagnosis:

1. Pyonephrosis (bilateral).
2. Bilateral duplication of ureters (incomplete).
3. Duplication of pelves (complete).
4. Dilated ureters above point of junction, the point of junction being strictured causing dilatation of ureters and pelves.
5. Hypertrophied bladder (chronic cystitis).

Microscopic examination of kidney: Diffuse infiltration of parenchyma by polynuclear cells; no evidence of tubercle formation. The pathologist's report says nothing of cysts though they were found in the gross specimens, so that I believe we also had here a congenital cystic condition. The immediate cause of death was uremia.

CHAIRMAN: The record is before you now for comment or criticism, discussion or questions.

DOCTOR —— What is the embryology in a case like this, doctor?

RESPONSE: The embryologist of our department is my associate, and he will answer the question.

EMBRYOLOGIST: In order to get an idea as to how these anomalies are formed, one must of necessity go back to the embryology of the urinary organs. I have therefore attempted to get the more important embryological points that explain the formation of these anomalies.

Embryology of Anomalies of Kidney and Ureter: In the development of the kidney we are concerned with the growth of three definite and distinct organs, which are formed at different stages in the growth of the embryo. These organs are known as the pronephros, mesonephros, and metanephros. The first two degenerate, while the third remains as the permanent kidney. The metanephros may be divided embryologically into two portions; one going to form the glandular or secretory portion of the kidney, and the other the efferent apparatus, i.e., the ureter, renal pelvis, and collecting system of tubules, all of which develop from what is known as the excretory duct. This duct serves the purpose of excretion during the embryonic development, and its cells multiply and give rise to the formation of ureter, renal pelvis and collecting tubules. The renal corpuscles and uriniferous tubules, as you know, go to form the glandular or secretory portion of the kidney, and ordinarily the uriniferous tubules join with the collecting tubules. Failure of these tubules to unite gives rise to what is known as the congenital cystic kidney.

A double ureter or double pelvis is caused usually by a double evagination of the primary excretory duct. By this is meant that cells of the primary excretory duct bud off, forming two separate buds which go on growing independently of each other, and form two ureters or pelves or both. A double pelvis may also arise from a deep ingrowth of a cortical column. You are all familiar with the appearance of the adult kidney, in section, showing the pyramids or medulla and cortex with wedges of cortical substance passing down between the pyramids. These wedges are the cortical columns and during (embryological) development one of these may prolong downward to such an extent as to divide the pelvis and sometimes the ureter.

The abnormalities of the ureter may be divided into two classes, i.e., the complete and the incomplete double ureter. In the former each ureter opens independently into the bladder. In the incomplete type the ureters on each side join before entering the bladder.

In conclusion, it is of practical importance to know that, where anomalies exist, the organs—the seat of such anomalies—are apparently prone to pathological lesions. To detect such an anomaly cystoscopy, examination of urine from each kidney, functional test, x-ray with catheters in place, and pyelo-ureterogram are necessary. Any mass in the abdomen calls for complete urological investigation and the ruling out or confirming of an anomaly, either renal or ureteral.

DOCTOR —— I would like to ask the doctor how old the child was.

RESPONSE: Eight months.

DOCTOR —— What, in your opinion, doctor, was the cause of that infection? The child apparently was healthy up to that time.

RESPONSE: I believe the child was not healthy up to that time. It may not have shown itself, but the chances are that that child had a pyelitis for some time and when there is an infection the openings of the ureters which were constricted are apt to become more constricted in the presence of the infection, and I dare say that was what caused a more marked tightening of the anastomosis between the ureters. This thinning out process that you can see in the specimen of the kidney substance did not take place in a week or in two weeks; it has taken several months.

DOCTOR —— Nothing to indicate that that child was ill previously?

RESPONSE: Nothing.

CHAIRMAN: Are there any other questions? The case is closed. Who has the record?

RECORD CRITIC: It is a pretty good record, Mr. Chairman, considering the case was an eight months old baby, but there are a few points in the history which should be taken up here. For instance, in the history it reads that the mother states the baby had a tumor in the abdomen. The physical examination sheet bears the O.K. of the attending physician, as is the custom, yet on the first follow-up note of the attending physician he makes the following abdominal findings: (The abdominal findings were read, showing that the interne found no tumor and that the attending did). There seems to be some discrepancy between the O.K. of the interne's findings and what was actually found.

Further along we have a consultation requested. It does not say of whom the consultation is requested, whether the pediatrist, the urologist, or the consulting surgeon. X-ray was also requested It does not say of the stomach, large intestine or small intestine, or any two or three parts of the same, to which reference is made.

Finally, I notice on the order sheet in no place does it appear that this eight months old baby got anything to eat. (Laughter.) That may seem ridiculous, but in the nurse's notes we find that the baby had milk every day at stated intervals. Whether that was modified milk, condensed milk or powdered milk, nobody knows. Whether the pediatrist was called in to feed the child, as he should have been, nobody knows. Apparently the baby's feeding depended on the nurse's charity. Otherwise, it is a good record. (Laughter.)

CHAIRMAN: Thank you, doctor.

The next case is one of carcinoma of the stomach; gastroenterostomy; death.

DOCTOR:——

Male, age 59, married, motorman.

Admitted: 3/6/24. Died: 3/25/24. Total time in hospital 19 days.

Admission diagnosis: Gastric Malignancy (from history).

Working diagnosis: Carcinoma of the stomach.

Final diagnosis: Carcinoma of the stomach.

Associated: Generalized arteriosclerosis.

Chief complaint: Burning pain in the epigastrium of 8 weeks' duration.

Past and Personal history: Irrelevant.

Present history: Burning in epigastrium which came on suddenly two months ago after eating highly seasoned food. The burning pain came on one hour after eating, lasting ten to fifteen minutes. Since then has had such sensations at other times during the day and regardless of the ingestion of food. The pain does not radiate, not severe and is not relieved in any way. Cramps in the epigastrium have been present for two months. They come on one or two hours after meals, do not radiate, are moderately severe and not relieved by vomiting. Gaseous eructations, nausea and occasional vomiting have been present. Patient has been on a strict diet for five weeks without relief of symptoms. Has lost fifteen pounds in weight in the last two months.

Physical examination on admission: Essentially negative.

Gastric analysis: Free HCL—0. Total HCL—8. Blood negative. Lactic acid negative.

X-Ray: Both 6, 24 and 48 hour films show gastric retention with irregular filling defect at the pylorus.

Transferred to surgical service.

3/20/24, operation: Partial gastrectomy with gastro-jejunostomy. Time of operation, 2 hours and 45 minutes. Anæsthetic—spinal (novocol) plus gas-oxygen.

Findings: Infiltrating growth of the pyloric region. Some enlarged glands in the gastro-hepatic omentum.

Postoperative: First day—abdomen soft and relaxed. Vomited once (old blood). General condition excellent. Pulse 84, good quality. Second day—stomach lavaged, 200 cc. of thick, black fluid withdrawn. Third day—stomach lavaged. Strychnine $^1/_{60}$ grain, t.i.d. Fourth day—patient allowed coffee by mouth. Medical consultation shows pulse bigeminal. Heart not enlarged. Blood pressure 110/64. Fifth day—patient waxy, weak. Pulse almost imperceptible. Respirations rapid and shallow. Abdomen soft and distended. Hypodermoclysis 500 cc. Blood transfusion 500 cc. Sixth day—patient became progressively worse and died at 6:15 P.M. Temperature first three days was normal; fourth and fifth days 97 degrees F. Pulse 80–100. Respirations normal.

Pathological report: Adeno-carcinoma of stomach. Urine negative. Blood count normal. Blood chemistry normal. Wassermann negative.

CHAIRMAN: The case is before you, gentlemen; are there any questions, comments or criticisms?

DOCTOR —— Did the patient die of peritonitis?

RESPONSE: Apparently not, from the negative abdominal examinations, postoperative.

DOCTOR —— Did the patient die of hemorrhage?

RESPONSE: Apparently not. There is only one record to indicate that the patient vomited, and one lavage showed dark, tarry fluid on the first day. There was no further vomiting after that.

DOCTOR —— Were there any intra-abdominal glands found on operation?

RESPONSE: Yes.

DOCTOR —— I think there was too much surgery done on this patient—two hours and forty-five minutes.

RESPONSE: A considerable proportion of that time was consumed by the poor anæsthesia. The operation was started under spinal, which was not successful, and then general anæsthesia with ether and gas oxygen was given, and considerable difficulty was experienced in getting the patient under the anæsthetic.

DOCTOR —— A more simple type of operation might have been done which would not have taken so long.

DOCTOR —— What was the cause of death?

RESPONSE: I believe the cause of death was a high intestinal obstruction.

DOCTOR —— May I ask where the spinal injection was made?

RESPONSE: I believe it was made between the eleventh and twelfth dorsal.

DOCTOR —— Could this fatality have been prevented, doctor?

RESPONSE: I do not know of any way that it could.

DOCTOR —— Mr. Chairman, what was the immediate postoperative condition of the patient?

RESPONSE: It was considered good, I believe.

DOCTOR —— Mr. Chairman, is it not rather strange to have this patient die of high intestinal obstruction when there were no signs of vomiting all this time?

CHAIRMAN: I believe you have some thoughts on that, have you not, doctor?

OPERATING SURGEON: I operated on this patient, and the excessive time for the operation was not due to too much surgery; we wasted at least half an hour before we opened the abdomen, because as long as the spinal anæsthesia did not work I wanted to give the patient gas and oxygen, but the patient kept arguing, and the clock did not stop. Then the gas apparatus went out of order and we wasted considerable time working on that. The actual operative work did not take longer than one hour and a half.

On the criticism of having done too much surgery—I believe we must remove the omentum when we find that we have glands in it, because there is no use in doing a gastro-enterostomy or a partial resection of the stomach and risking the patient's life, and taking a chance of having a recurrence of the cancer in six months. The cause of death, therefore, cannot be ascribed to any prolonged surgery, but there is one fact—this patient, if you notice, had a normal pulse, a normal temperature, a soft abdomen, could drink on the third day, and was very cheerful up until the third day. We could have given him milk and whiskey and coffee. He did not have peritonitis because he did not have temperature; his pulse was good, the abdomen was soft, there was absolutely no gas, no distention, no pain. Inasmuch as I had another similar case I began to consider why the patients died. My findings are as follows, and I offer this as an explanation, and then I will try to give the remedy:

(Drawing diagram on board): This is a very poor outline of the stomach (I do not pretend to be a good draftsman). When we remove a portion of the stomach we remove this portion of the stomach and just bring up the intestine here somehow, by different methods. I am making this schematically. We close the duodenum, we close the stomach, and we bring up the stomach so that it can open into the jejunum. No matter what our idea is about surgery of the stomach, when we resect the stomach and separate the stomach from the duodenum, we certainly cut the roadway through which peristalsis is running. Therefore, after we have separated the stomach from the duodenum we have this fact—that the duodenum does not receive the peristaltic impulses that it did before the operation, and in all experimental work I have found that we had a paralysis of the duodenum. But the duodenal content will stagnate in the duodenum. We know that stagnation of the duodenal content turns this fluid into a highly toxic product; it is the most highly toxic product we have in the body. Therefore, what happens? We have the same symptoms in these cases as we have when we have high obstruction in the duodenum.

This case was perfectly well up until the third day; he could drink, but we could see him wasting away. From the third until the fifth day, you could see the man really wasting away; he was clammy cold; his pulse was getting more rapid, and finally he died of exhaustion.

Now what would be the remedy? The remedy, I should say, could be applied in three ways: One, if we could put a tube in the duodenum and drain off the toxic accumulation; two, another tube into the duodenum for giving fluids; and three, a tube into the stomach for lavage. These patients like to drink and will do anything to get a drink—I found one recently drinking from the Murphy drip. So if we put a certain amount of fluid through the tube into the duodenum we satisfy their thirst without actually resorting to drink.

On the third day, in experimenting, we find that the duodenum is paretic, distended, full of chocolate colored fluid in all cases. Therefore, these cases die from a condition similar to high intestinal obstruction which is due to paresis of the duodenum following the obstruction from the stomach, where the peristaltic waves have to find a means whereby to start the normal peristalsis.

CHAIRMAN: Is there any comment or criticism?

DOCTOR —— Is it not possible that if the patient had not got anything by mouth for a few days longer he might have lived? Might he not have been killed by kindness?

RESPONSE: I do not believe so, because this patient really wanted to drink, and did drink and felt more comfortable, and he liked it, so why should we not have given him more fluid by mouth when there was no reason not to give it?

DOCTOR Mr. Chairman, not every gastrectomy dies from this. What happened in this particular case, and why does it not happen in all of them?

RESPONSE: That is the same as the question, why some patients die from some operations and some get well in other cases. (Laughter.) When a patient is so low that he cannot stand this amount of toxemia, then he may die from toxemia. If the patient is younger or stronger or has not so much absorption, or for some other reason has a better advantage, then, of course, he recovers.

CHAIRMAN: Is there anything else? Are there any other thoughts? Discussion of the case is closed. Who has the record?

RECORD CRITIC: There is no criticism of the record.

CHAIRMAN: When the original program for this demonstration was prepared we were under the impression that we would have more time than has proven to be the case this afternoon, so that the next case will be the last in the series, that being about half the number of cases and about half the time approximately that an ordinary conference takes.

Now I will take just a minute to point out to you, if you will allow me, the value of the conference. First, as a check-up on records. You cannot have staff conferences unless you have records. The record is the basis of the conference. If you have not got records staff conferences will bring them to you, and if you have records, staff conferences will make them better. The teaching value of the conference will, I think, be best exemplified by the case which is about to be reported—a case on my own service, of pneumococcic peritonitis, unrecognized as such; confirmed by postmortem aspiration and culture and smear of pus; a review of the literature bringing to light an article which had escaped attention, by McCartney and Fraser in the British Journal of Surgery in 1921, followed by the admission to the hospital within ten days of a patient with pneumococcic peritonitis, promptly recognized by one of the men who had attended the conference at which this case had been reported; operation and recovery.

DOCTOR ——

Female child, age 8, U. S. of Italian parentage, schoolgirl.

Admitted: 9/24/23. Died: 10/2/23. Total time in hospital 8 days.

Admission diagnosis: Acute appendicitis.

Working diagnosis: Pneumonia, T.B. peritonitis.

Final diagnosis: Acute pneumococcic peritonitis.

Cause of death: Acute pneumococcic peritonitis.

Present history: Child taken sick 3 days prior to admission with pain in abdomen, nausea, vomiting and diarrhea. Pain at onset was general, over entire abdominal area, but on day of admission was localized in l.r.q. There was fever.

Previous history: Measles, whooping cough, tonsils and adenoids removed one year ago. Otherwise negative.

Physical examination: T. 102; P. 120; R. 30.

Female child, fairly well nourished, acutely ill. Tongue dry, slightly coated, sordes present, teeth in fairly good condition.

Chest: Expansion greater on left side than on right. Resonance diminished over right base posteriorly. Crepitant rales, friction sound and distant breathing over right base; few scattered, crepitant rales in left lung.

Abdomen: Distended, soft, pliable, uniformly tender, no muscle spasm.

Examination otherwise negative.

History impression: Broncho-pneumonia with pleuritis.

House physician's note: Lungs clear; abdomen distended, moving slightly with respiration; peristalsis audible; no rigidity; right rectus slightly spastic; generalized moderate tenderness, more marked on right side; no mass felt; slight dullness in r.l.q.

Rectal examination: Slight tenderness in cul de sac.

Impression: 1. Typhoid fever. 2. Influenza.

Attending's note: Abdominal examination does not suggest any surgical condition. Requested medical consultation.

Laboratory data: Urine, faint trace of albumin, otherwise negative. Blood R.B.C. 3,780,000; Hgb. 75 per cent; W.B.C. 7,400; Polys. 81 per cent. Vaginal smear negative for gonococci. Blood culture 9/27 sterile. Catheterized specimen of urine 9/28 showed 5 pus cells per field and B. Pyocyaneus on culture. Feces, negative for blood or ova.

Progress while in hospital: Further examination of chest practically confirmed interne's findings.

9/26–27–28, there was no change, medical side noting that lung signs were clearing up. Temperature ranged between 100 and 104 degrees; pulse 120 to 140; respirations from 24 to 52.

9/26, bedside x-ray of chest was negative for lung pathology.

Distention with vomiting and drowsiness continued. Stools were frequent, green, watery.

9/30, medical attendant regarded condition as possible tubercular peritonitis.

10/1, second blood culture showed pneumococci and interne notes possibility of pneumococcal peritonitis. The leucocytosis was then 14,600; 89 per cent polys.

10/2, assistant on surgical side believed condition to be general peritonitis and suggested stab wound drainage. This was concurred in by the medical side, but the attending surgeon did not agree.

10/2, 7:30 p.m. child expired.

Aspiration of abdomen disclosed thick, yellow pus which on smear showed numerous diplococci, morphologically similar to pneumococci, and on culture, pneumococci.

CHAIRMAN: Is there any comment or question or criticism?

DOCTOR —— Were tuberculin tests done on this case?

RESPONSE: No, sir.

CHAIRMAN: Did the service prepare anything on the question of pneumococcic peritonitis?

DOCTOR —— Yes, sir.

CHAIRMAN: I may say that this abstract of the literature was originally very lengthy and very complete, but for the purpose of this demonstra-

tion has been cut down considerably. Will you kindly read it, doctor?

REVIEW OF LITERATURE OF PNEUMOCOCCIC PERITONITIS

This review covers the literature of the last five years available at the Library of the Medical Society of the County of Kings covering eleven essayists and ten journals, the geographical range comprising Cuba, Italy, Scotland, England and the United States. Of the articles some are case reports, others are lengthy and ambitious efforts to analyze, describe and classify this disease. Notable among these are Parker Syms, Annals of Surgery, Gibson and Johnsons, Surgical Clinics of North America. A very scholarly, comprehensive and impressive review is that of McCartney and Frazier, Edinburgh, Scotland, British Journal of Surgery, 1918.

The problems involved are of etiology, diagnosis, treatment and classification. There is a diversity of opinion as to etiology, some contending that the infection is hematogenous from the lungs or middle ears, some believing that it occurs by direct lymphatic extension from the thorax; others aver that the infective route is per vaginam.

Most observers feel that diagnosis is difficult. Gibson, however, thinks the clinical picture is clean cut, the diagnosis simple.

All agree that the onset is typical of acute peritonitis, with elevation of temperature, pulse and respiration. Gibson says that vomiting is irregular, not persistent; that there is general abdominal distention with much less tenderness and resistance than would be expected. The patients are obviously sick but in better condition than in peritonitis due to other causes, such as appendicitis. All show hebetude, some have herpes labialis. He emphasizes the importance of these symptoms: (1) Pain, constant, early, lower abdomen at first, later whole abdomen; (2) Diarrhea; (3) Torpor; (4) Distention, tenderness, resistance, two latter not marked; (5) Temperature and pulse high; (6) Leucocytosis—20 to 50,000.

As to classification, there is unanimity, that is, there are two recognized types, localized and generalized. The local type is either subumbilical or hypogastric.

As to treatment Gibson advocates early operation and drainage, as in a series of six patients he had only 16 per cent mortality as compared with 86 per cent reported by Annand and Bowen. He further suggests serum treatment as desirable, using Type I serum until the identity of the strain is effected. It is usually I or II.

At operation the findings are: (1) Large amount of fluid, pearly or milky white, with relatively mild peritoneal irritation; (2) No odor; (3) No adhesions or agglutination early.

Provinciali, Pediatrics Itala, Naples, 1921, believes port of entry is external genitalia and mentions the value of exploratory puncture as a diagnostic aid.

Beaven, Am. Journal, Diseases of Children, 1920, considers infection is blood borne from the lungs, Brunn, from the middle ear, while Annand, Bowen, Jensen, Cameron, believe the focus is in the intestine.

McCartney and Frazier, Edinburgh, British Journal of Surgery, 1921–1922, write a masterly analysis and summation of this problem, done with a thoroughness and attention to detail that command admiration.

"Among the acute abdominal emergencies of childhood, pneumococcal peritonitis ranks as one of the most serious; as one which is associated with perhaps the highest scale of mortality. Its occurrence is not confined to children, but the proportional incidence is so vastly greater in the child than in the adult that it has come to be looked upon as a disease of childhood and youth.

"Even in childhood it cannot be described as a common disease. It is impossible to give figures by which to form an estimate of the proportional occurrence, but probably about two per cent of the abdominal emergencies of childhood are due to abdominal pneumococcal infection. In this connection, however, it must be noted that a proportion of pneumococcal peritoneal infections are not diagnosed as such, and the occurrence of the condition is more common than we realize. Evidence which may be said to support this assertion is afforded by statistics showing the admission figures of the disease during the years 1902–1911 and 1920—the admissions were 4, 7, and 15, respectively. The probability is that, while the actual proportional occurrence has remained constant, the class of case is now more efficiently recognized and is submitted to surgical interference at an earlier period.

"For certain reasons a study of the disease is attractive. Its mortality is so high that any additional knowledge which will tend to reduce that mortality must be welcome; the apparently idiopathic nature of the affection in certain cases stimulates investigation, and there are a number of clinical points which arise in connection with the disease and which are of interest from the symptomatic point of view.

"An investigation has been made, therefore, of a series of 56 cases which have come under treatment at the Children's Hospital, Edinburgh. In this institution the age limit is fixed from birth to twelve years, and therefore the cases have all fallen within this period."

They classify the disease into:

A. Primary, (1) Acute, (2) Chronic

B. Secondary cases,

and proceed to consideration of the mode of infection—

(1) Blood Stream. This has been definitely disproved by Blake and Cecil. They showed in experimental work on monkeys that pneumonia could only be produced

by intratracheal injection of pneumococci, one millionth of a c.c. of broth culture causing severe or fatal pneumonia, and that the organisms appeared in the blood in from 6 to 24 hours, often before clinical evidence of pneumonia or elevation of temperature developed. They further showed that intravenous injection of pneumococci caused septicemia but not pneumonia or peritonitis.

Furthermore, as pneumococci gain access to blood stream in practically all pneumonias, peritonitis should be common. Actually, it is rare, Rolleston's figures being 11 cases in 4,454 or 0.24 per cent.

(2) Gastro-intestinal Tract. This theory is based on the fact that pneumococci are found in the intestinal flora and in the subperitoneal tissues of the intestinal wall in pneumococcic peritonitis. Contraverting this is that pneumococci are frequently, though not commonly, found in the bowel content and that the subserous occurrence represents invasion from overlying peritonitis. They have never been demonstrated without peritonitis. Mucous lesions have never been demonstrated, and Jensen and the authors experimented extensively on rabbits, feeding them with as much as 10 c.c. of virulent cultures, with bicarbonate of soda to neutralize acidity, and opium to slow peristalsis, without causing peritonitis.

(3) Lymphatic Route. This is dismissed as it predicates infection against the lymphatic current and a massive lymphatic infection that has no parallel in pathology.

(4) Genital Tract in the Female. The peritoneal cavity of the female is in communication with the exterior through the genital tract, an important fact. Milcher in 14 cases, studied exhaustively, of tuberculous peritonitis in females proved conclusively that 12 of them owed the infection to the internal reproductive organs.

The authors believe that primary pneumococcal peritonitis is a disease peculiar to the female sex. In 56 patients at the Children's Hospital, Edinburgh, no primary case was seen in a male. Of the 56, 12 were boys, 44 girls. The boys were all secondary cases, 10 following lobar pneumonia, most often right side. Of the 44 girls, 8 were secondary, 36 primary.

Evidence favoring genital infection—

(1) It is mainly found among the poor, neglected, unhygienic children, due to imperfect genital hygiene, direct contamination and association with other children. Vaginal smears frequently show organism resembling pneumococci, some of which were pathogenic. Among better class patients this did not obtain.

(2) In last 10 cases operated swabs were taken from upper and lower abdomen, vagina and throat, and blood cultures made and the growths typed.

In all cases a much "heavier" infection was found in the pelvis than in the upper abdomen; in one early case pneumococci were easily demonstrated in the cul-de-sac but not in the upper abdomen. In every case pneumococci were isolated from the vaginal swab, and the individual organisms isolated were all of the same type. Eight were type I, two type II, the latter rare in children. In one case a throat culture showed type IV, and the abdomen, vagina and blood stream showed type I.

The blood shows organisms early, the authors recovering pneumococci from the ear of a rabbit four minutes after intra-peritoneal injection of pneumococci.

They quote Bone who demonstrated an ascending mucous current in the vagina by injecting coloring matter into the vagina, which eventually was found distributed over the parietal peritoneum, contacting with the tubal fimbriæ, additional evidence of the existence of a channel for pneumococci to travel along.

(3) Age Incidence. Most frequent from third to seventh years, fifth and sixth greatest. At birth the walls of the vagina are in contact and only freely separate after the third year. The vaginal secretion is alkaline up to the seventh or eighth year, then becoming acid, another possible factor to be thought of.

Clinical evidence favoring pelvic port of entry—

(1) Superficial pain.
(2) Pain on, and frequency of micturition.
(3) Diarrhea, presumably due to irritation of pelvic colon and lower ilium.
(4) Early operation shows greatest damage in pelvic serosa.

Clinical peculiarities—

There are two types of primary disease: the acute, fulminant type with death soon after 24 hours, then the chronic, often simulating tuberculous peritonitis. Sequence of events best seen and studied in moderately severe case.

There is an introductory period when infection is localized in pelvis. About the third day on the average comes the second stage, that of septicemia. This is the critical period and is recognizable by the dramatic change, restlessness, cyanosis, rapid respiration, exaggerated action of the alæ nasi, delirium, hyperpyrexia, and rapid pulse. Some patients never enter upon this stage, becoming the chronic or encysted type.

Individual peculiarities—

(1) Excessive vomiting early in the disease, so intense as to have been regarded as the result of central nervous involvement.
(2) Diarrhea, early, severe, constant. Of 36 patients 32 had it. Four who did were of the fulminant type.
(3) Frequent and painful micturition.
(4) Change in clinical features coincident with development of septicemia when the abdominal signs become masked by the acute general signs and symptoms of pneumococcal septicemia.

Operative findings—

At early operation only lesion seen is a film of exudate, oily or sticky, over the pelvic viscera.

This has a tendency to cause adhesions but disappears as the effusion becomes more fluid. After 24 hours the exudate becomes watery and profuse, brownish color with flakes or lymph and fibrin. Only after the fourth day does it become purulent. *Delay in leucocyte migration is an indication of the intensity of the infection* and is an unfavorable prognostic sign. Peritoneum is plum colored. The small bowel is distended. The fimbriæ are congested and often muco-purulent material may be expressed from them. Blood and urine chlorides are diminished. Leucocytosis is definite. In septicemia state the H ion content of the plasma is reduced.

Post mortem examinations were carefully made. No other focus could be found, especial attention having been given to the middle ear. Fallopian tubes in all cases were congested, showed a catarrhal inflammation and invariably pneumococci.

TREATMENT

They quote statistics of Rischbreth, who takes a pessimistic view, having found mortality of 88 per cent in collected statistics from the London hospital. He advises against operation except in encysted cases where mortality is 30 per cent.

The authors, however, urge early operation. As soon as recognized the peritoneal cavity is drained under gas oxygen, drainage being instituted at the most dependent part, often through the vagina (good results). This is supplemented by citrate transfusion, parents as donors, 250 c.c. at six years of age being given. The precise time when transfusion is most helpful is when the evidences of septicemia begin to appear; if earlier, it does not prevent septicemia; if later, not beneficial. Change after transfusion is often striking.

Mortality at their hospital on operated patients covering 20 years was 65 per cent. In 1920, with earlier operation and better anæsthesia it was 53 per cent, and in 1921, with transfusion added it was 42 per cent.

CHAIRMAN: Now, if you will recall, the sequence was first the case unrecognized, then the review of the literature. Now let us see what happened to the next one.

DOCTOR ——

Female, age 5.

Admitted: 11/8/23. Discharged: 12/1/23. Total time in hospital 22 days.

Admission diagnosis: Acute appendicitis.

Working diagnosis: Acute general peritonitis.

Final diagnosis: Pneumococcic peritonitis.

Complications: Acute lobar pneumonia.

History: Chief complaint—pain in abdomen.

On 11/4/23, four days before admission, patient had headache, sore throat, cough, vomiting and fever. She received treatment and was up and about until 11/7/23, when she complained of malaise and fever.

On 11/8/23 she complained of abdominal pain about the umbilicus. Had headache, no vomiting. The abdominal pain persisted, was not relieved by enemata and was aggravated by cathartics.

Physical examination: Frail young female, acutely ill, legs flexed on abdomen. Head—negative. Chest—negative. Heart—apex 6th space nipple line, sounds rapid, good quality, no murmurs. Abdomen—normal contour, not rigid but somewhat spastic. Tenderness over entire abdomen, greatest in region of umbilicus and to right of it; no masses. Tender over kidney area.

Opinion: 1. Acute appendicitis. 2. Pyelitis.

On 11/8/23, the night of admission, a surgeon was called in consultation. At that time temperature was 104, pulse 136, respirations 40. The surgeon made the following note: Child lying partially on left side with thighs and knees flexed. Respirations rapid; slight grunt; no dilatation of ala nasi.

Abdomen does not show marked distention. It moves with respiration, is soft; no spasticity; no masses noted. Tenderness present, especially in lower abdomen, on both sides, also in both costo-iliac spaces.

Impression: 1. Pneumococcic peritonitis. 2. Pyelitis.

Advise: Urine examination and observation.

W. B. C. 28,800; Polys. 86; Small lymphs. 14; Urine showed many pus cells.

Early in the morning of 11/9/23, with the above report from the interne, the following note was made: Tenderness over right kidney area more marked. Abdominal signs same.

Opinion: In view of urinary findings and negative chest, consider case pyelitis with perhaps some intra-abdominal condition.

In the afternoon of 11/9, the surgeon again examined patient and made the following note: Pain and tenderness marked. Spasticity more definite today. Dullness on percussion in r.l.q.

Opinion: Pneumococcic peritonitis.

Advise: Laparotomy under local. Complete blood count, sahli. Smear from vagina; blood culture.

Temperature 100.4; pulse 100; respiration 38.

Complete blood examination: R.B.C. 4,050,000; Sahli 60 per cent; W.B.C. 20,200; Polys. 89 per cent; Small lymphs. 11 per cent.

Smear from vagina showed pneumococci.

Operation was performed by the consulting surgeon on 11/9/23.

Operation: Laparotomy for acute general peritonitis (pneumococcic) under procain (infiltration) anæsthesia.

Incision: Low median.

Findings: Abundant thin, gray fluid, odorless. Peritoneum deeply injected, purplish red in color.

Procedure: Pus evacuated; culture taken; 2 Penrose tubes introduced.

Culture showed pneumococci.

Post operative course: The abdomen drained freely, and the general condition remained stationary until 11/20/23, eleven days after operation, when acute lobar pneumonia, right base, developed. This ran a short, sharp course, and on 12/1/24 child was discharged to her home where treatment was continued until 1/18/24, when the abdominal wound healed.

CHAIRMAN: Any question or comments?

DOCTOR —— One must occasionally be careful not to accept the pneumococcus there as being such. Sometimes we will find the streptococcus in primary cases. The time of the pneumococcus and

streptococcus infections are about the same. So that clinically, except for the fact that there was an early sore throat and thorough studies of the bacteriology, one very often would confuse the two.

CHAIRMAN: Is there any further discussion? If not, the case is closed.

For the staffs of the two hospitals, I thank you for your patience and indulgence, and hope that you have found the demonstration worth while.

TENTATIVE PROGRAM OF THE HOSPITAL STANDARDIZATION CONFERENCE

BELLEVUE-STRATFORD HOTEL, PHILADELPHIA, OCTOBER 26–30, 1925

A MOST interesting and instructive program is now under way for the Hospital Conference of the Clinical Congress of American College of Surgeons to be held at the Bellevue-Stratford Hotel, Philadelphia, October 26–30 next. This program will consist of addresses, papers and discussions dealing with the various aspects of hospital standardization, such as organization, facilities, personnel, procedures, and end results, and will be of particular interest throughout to hospital trustees, executives and personnel generally, as well as members of the medical profession—physicians, surgeons and specialists. Considerable time will be devoted to the discussion of minimum standards for various clinical services and departments in hospitals. The subjects to be discussed have been selected after a careful survey made recently of the hospital field.

A Hospital Information and Service Bureau will be maintained throughout the Congress to give assistance to any hospitals in the solution of their problems.

A general invitation is extended to hospital trustees, hospital personnel, members of medical staffs and the medical profession generally to attend all the sessions of the Hospital Conference.

The following is a tentative outline of the program:

OPENING ADDRESS
Charles H. Mayo, M.D., Rochester, President.

PRESENTATION OF THE EIGHTH ANNUAL REPORT OF HOSPITAL STANDARDIZATION
Franklin H. Martin, M.D., Chicago, Director General American College of Surgeons.

THE RESPONSIBILITY OF THE FELLOWS OF THE AMERICAN COLLEGE OF SURGEONS IN HOSPITAL STANDARDIZATION
LeRoy Long, M.D., Oklahoma City; Dean and Professor of Surgery University of Oklahoma School of Medicine.

THE HOSPITAL, THE DOCTOR AND THE NURSE AS COOPERATING FACTORS IN THE CARE OF THE PATIENT
W. T. Henderson, M. D., Mobile; Visiting Surgeon Providence Infirmary, Mobile City Hospital.

THE EMINENT HOSPITAL
Rev. C. B. Moulinier, S. J., Milwaukee; President Catholic Hospital Association.

THE APPLICATION OF AMERICAN COLLEGE OF SURGEONS STANDARDS IN THE MODERN HOSPITAL
W. L. Foss, M.D., Danville, Pa.; Surgeon in Chief Geisinger Memorial Hospital.

THE HOSPITAL OF THE FUTURE
Newton E. Davis, Chicago; President American Protestant Hospital Association.

THE RÔLE OF THE MEDICAL STAFF IN HOSPITAL EFFICIENCY
J. Garland Sherrill, M.D., Louisville; Professor of Surgery, University of Louisville Medical Department.

WHAT THE AMERICAN COLLEGE OF SURGEONS CAN DO FOR THE SMALLER HOSPITAL
Paul H. Fesler, Oklahoma City; Superintendent State University Hospital.

HOSPITAL EFFICIENCY FROM THE VIEWPOINT OF THE INTERNIST
Alfred T. Stengal, M.D., Philadelphia; Professor of Medicine University of Pennsylvania, President American College of Physicians.

POLITICAL INTERFERENCE IN HOSPITALS
Rudolph Matas, M.D., New Orleans; Professor of Surgery Tulane University; President-Elect, American College of Surgeons.

POST MORTEMS IN HOSPITALS—
Findings in the State of Pennsylvania Survey
Frank C. Hammond, M.D., Philadelphia; Dean and Professor of Gynecology, Temple University Department of Medicine.
Relation of the Surgeon to Post Mortems
Charles Bagley, M.D., Jr., Baltimore, Associate in Experimental Neurology, Johns Hopkins University Medical Department.
Post Mortems in the Open Hospital
Israel Brown, M.D., Norfolk, Va.; Surgeon St. Vincent's Hospital and Sanitarium.

END RESULTS AND FOLLOW-UP
Henry L. Page, M.D., Philadelphia; Medical Director Lankenau Hospital, and Miss Annie M. Jastrow, Philadelphia; Director of the Follow-Up Service Lankenau Hospital.

ESSENTIALS FOR AN EFFICIENT FRACTURE SERVICE IN A HOSPITAL
Charles L. Scudder, M.D., Boston; Consulting Surgeon Massachusetts General Hospital.

SYSTEMATIC COLLECTION AND OFFICIAL PUBLICATION OF OPERATIVE MORTALITIES AS A MEANS OF FOSTERING SURGICAL ACCOUNTANCY
Robert L. Dickinson, M.D., New York; Senior Gynecologist and Obstetrician Brooklyn Hospital.

ROUND TABLE CONFERENCES

Conducted by Joseph C. Doane, M.D., Philadelphia; Medical Director and Superintendent Philadelphia General Hospital and John D. Spelman, M.D., New Orleans; Superintendent Touro Infirmary.

The following problems have already been suggested for discussion:

The relation and responsibility of the hospital administration in preoperative preparatory procedures.

The relations and responsibilities of the interne.

The best methods of making more efficient the instruction and experience of the internes and nurses in the surgical department.

Responsibility of the surgeon in promoting economies in the surgical department.

The most efficient arrangement of concurrent staff services in relation to duty.

The essentials for an efficient anæsthetic department.

Supervision and control of the surgical department.

The "open hospital" policy.

The best means for handling extra charges for special services.

The education of new trustees in regard to the hospital and its workings.

The status of the hospital superintendent.

The hospital and the private duty nurse.

The ownership of the case record.

The best means of improving the quality of case records.

The relations of medical staff to board of trustees.

A plan of procedure in selecting members of the medical staff and extending privileges to doctors to practice therein.

The supervision of surgical work in the hospital.

The relative advantages and disadvantages of continuous versus divided ward services in a hospital.

In addition to the above program, so far as time permits, group conferences on hospital service will be arranged. These conferences will include discussion of the following clinical services and departments: Internal Medicine, Ophthalmology and Oto-Laryngology, Obstetrics, Urology, X-ray, Clinical Laboratory and Case Records. Discussion in connection with each of these will deal mainly with organization, facilities, personnel and procedures for the various services and departments mentioned, and in every way will be of practical value to those in attendance.

The Philadelphia Hospital Association has offered its heartiest co-operation during the week in seeing that the hospital people visiting Philadelphia have a most profitable and pleasant time. It is a well recognized fact that Philadelphia is one of the greatest hospital centers on this continent. The local Association has organized the hospital facilities and activities in the City so that complete and valuable information can be readily secured on every problem relating to the hospital field. There is no doubt that the week spent in Philadelphia will be of the greatest value to hospital executives, personnel, trustees and others interested in this work. Full particulars of the entire program will appear later.

CLINICAL CONGRESS OF AMERICAN COLLEGE OF SURGEONS

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PRELIMINARY PROGRAM FOR THE PHILADELPHIA MEETING

THE program for the fifteenth annual session of the Clinical Congress of the American College of Surgeons, to be held in Philadelphia October 26 to 30, as published in the following pages is merely an outline of the program being prepared by the Committee on Arrangements. During the coming months the program is to be revised and greatly amplified under the supervision of the Committee on Arrangements so that the final program will represent completely the clinical activities in all departments of surgery in that great medical center.

An important feature of the program will be a series of demonstrations or "dry clinics" at the larger hospitals in which the surgeons, internists, pathologists, roentgenologists, and other specialists will participate to discuss some of the more important phases of surgery.

Another series of clinical demonstrations, dealing with surgical aspects of ophthalmology, otology, rhinology, and laryngology, will be given each forenoon in the Ballroom of the Bellevue-Stratford to supplement the clinical work in the hospitals in the afternoons. Thus a full program of clinical work will be provided for each of the four days of the session for those who are interested in surgery of the eye, ear, nose, and throat.

General headquarters of the Congress will be established at the Bellevue-Stratford Hotel, Broad and Walnut Streets, where the entire first floor, including the Ballroom, Clover Room, Rose Room, Gold Room, together with the Stratford Room on the main floor and the Rose Garden and other rooms on the roof, have been reserved for the exclusive use of the Congress. These rooms provide ample space for evening meetings, business sessions, hospital standardization headquarters, registration and ticket bureaus, bulletin rooms, etc.

A number of fine large hotels, situated within easy walking distance of the Bellevue-Stratford,

have been erected since the last meeting in 1921, so that the hotel situation in Philadelphia has been greatly improved. See list of hotels with their rates below.

An application for reduced railway fares on account of the meeting in Philadelphia is pending with the railway passenger associations and it seems assured that a substantial reduction in fares will be granted applying to all sections of the United States and Canada.

EVENING MEETINGS

Monday—Ballroom, 8: Presidential Meeting. Address of Welcome, Charles F. Nassau, M.D., Chairman of Philadelphia Committee on Arrangements; Address of Retiring President, Charles H. Mayo, M.D., Rochester, Minn., Introduction of Foreign Guests; Inaugural Address, Rudolph Matas, M.D., New Orleans; The Doctor John B. Murphy Oration in Surgery, Sir William Arbuthnot Lane, Bt. London, England.

Tuesday, Wednesday, and Thursday—Ballroom, 8: Scientific papers and discussions, general surgery, etc., including the following: "Congenital Dislocation of the Hip," by Professor Vittorio Putti, Bologna, Italy; "The Treatment of Chronic Ascending Infections of the Uterus and Adnexa by the Bell-Beuttner Operation with Ovarian Conservation or Grafting," by W. Blair Bell, M.D., M.R.C.S., Liverpool, England.

Friday—Ballroom, 8: Thirteenth Convocation of the American College of Surgeons, Invocation; Conferring of Honorary Fellowships; Presentation of Candidates for Fellowship; Presidential Address, by Rudolph Matas, M.D., New Orleans; and the Fellowship Address by The Right Hon. Lord Dawson of Penn. G.C.V.O., C.B., London, England, Physician in Ordinary to H.M., The King, who will be the guest of the Philadelphia Clinical Congress.

Wednesday Morning: Philip Franklin, F.R.C.S., London, England, will give a paper on "The Clinical Aspects of Tonsils" at one of the special sessions of the eye, ear, nose, and throat section.

LIMITED ATTENDANCE

Attendance at the Philadelphia session will be limited to a number that can be comfortably accommodated at the clinics, the limit of attendance being based upon the result of a survey of the amphitheaters, operating rooms, and laboratories in the hospitals and medical schools as to their capacity for accommodating visitors. This plan necessitates registration in advance on the part of all who wish to attend. When the limit of attendance has been reached through advanced registration, no further applications can be accepted.

Attendance at clinics and demonstrations will be controlled by means of special clinic tickets, which plan has proved an efficient means in the past for providing for the distribution of visiting surgeons among the several clinics and insures against overcrowding, as the number of tickets issued for any clinic is limited to the capacity of the room in which that clinic is given.

REGISTRATION FEE

A registration fee of $5.00 is required of each surgeon attending the annual clinical meeting, such fees providing the funds with which to meet the expenses of the meeting. To each surgeon registering in advance a formal receipt for the registration fee is issued, which receipt is to be exchanged for a general admission card upon his registration at headquarters during the meeting. This card, which is nontransferable, must be presented to secure clinic tickets and admission to the evening meeting.

PHILADELPHIA HOTELS AND THEIR RATES

	Minimum Rate for Room with Bath	
	Single	Double
Adelphia, Chestnut and 13th Sts	$4.00	$8.00
Bellevue-Stratford, Broad and Walnut Sts	5.00	8 00
Benjamin Franklin, Chestnut and 9th Sts	3.00	6.00
Green's, 8th and Chestnut Sts	3.50	5 00
Longacre, Walnut St. West of Broad	4.00	6.00
Lorraine, Broad St. and Fairmont Ave	2.50	5 00
Majestic, Broad St. and Girard Ave	4.00	5.00
Robert Morris, 17th and Arch and the Parkway	3.00	5 00
Pennsylvania, Chestnut and 39th Sts	3.00	6 00
Rittenhouse, Chestnut and 22nd Sts	3.50	5 00
Ritz-Carlton, Broad and Walnut Sts	6.00	10 00
Spruce (Men Only), Spruce and 13th Sts	4.00	. . .
St. James, Walnut and 13th Sts	3.50	5.00
Stenton, Broad and Spruce Sts	5.00	7.00
Sylvania, Locust and Juniper Sts	4.00	6.00
Walton, Broad and Locust Sts	3.00	5.00

GENERAL SURGERY, GYNECOLOGY, OBSTETRICS, ORTHOPEDICS, UROLOGY

JEFFERSON HOSPITAL

Tuesday

J. Torrance Rugh—9:30. Orthopedics.
Charles F. Nassau—11. General surgery.
Thomas C. Stelwagen—11. Genito-urinary surgery.
John H. Gibbon—2. General surgery.

Wednesday

Chevalier Jackson—9. Bronchoscopy for diagnosis and treatment of diseases of the lungs.
Brooke M. Anspach and Staff—9. Gynecology.
P. Brooke Bland—9. Gynecology.
W. H. Kinney—11. Genito-urinary surgery.
John B. Flick—11. General surgery.
J. Chalmers DaCosta—2. Surgical clinic.

Thursday

H. R. Loux—9. Genito-urinary surgery.
J. M. Fisher—11. Gynecology.
Thomas A. Shallow—11. General surgery.
Arthur Davidson—11. Orthopedic surgery.
Chevalier Jackson, Gabriel Tucker, and Louis Clerf—12:30. Bronchoscopic aspiration in suppurative diseases of the lung.

Friday

Edward J. Klopp—11. General surgery.

EPISCOPAL HOSPITAL

Tuesday

Ralph S. Bromer—9. X-ray demonstration.
Louis H. Mutschler—11. Operative clinic, general surgery.

Wednesday

Astley P. C. Ashhurst, Irvine M. Boykin, and Edward T. Crossan—9. Operative clinic, general surgery.
A. Bruce Gill, Rutherford L. John, and Albert F. Moxey—2. Orthopedics.

Thursday

E. G. Alexander—9. Operative clinic, general surgery.
H. C. Deaver—11. Operative clinic, general surgery.

Friday

E. T. Crossan—9. Demonstration in surgical pathology.
L. H. Mutschler—11. Operative clinic, general surgery.
John B. Haines—2. Cystoscopic clinic.

ORTHOPEDIC HOSPITAL

Tuesday

Astley P. C. Ashhurst, Rutherford L. John, Edward T. Crossan, and B. F. Buzby—1. Orthopedic demonstration.

Thursday

Astley P. C. Ashhurst, Rutherford L. John, Edward T. Crossan, and B. F. Buzby—9. Orthopedic operations.

Friday

A. Bruce Gill, C. R. Bowen, and James E. Wyant. Orthopedic clinic.

METHODIST EPISCOPAL HOSPITAL

Tuesday

James H. Baldwin—9. Gas gangrene, foreign body in bladder, fractures of patella, foreign body in brain.
Milton F. Percival—9. Daily demonstrations of X-ray technique, fluoroscopy, pyelograms, electrocoagulation, radio knife, and photography.

Wednesday

William R. Nicholson—9. Vesicovaginal fistula, cystocele, prolapse of uterus, cervical repairs, and repairs of perineum.
Levi Jay Hammond—2. Surgery of gall tracts, stomach, spleen, and pancreas.

Thursday

Damon B. Pfeiffer—9. Carcinoma of the rectosigmoid, blood transfusions, surgery of the gall bladder, stomach, and intestines.
Richard C. Norris—2. Abdominal gynecology, retroversion, uterine and ovarian tumors, cæsarean section.

Friday

J. T. Rugh—9. Arthrodesis, correction of paralytic deformities, stabilization of the hip joint and spinal bone grafts.
Leon Herman—1. Prostatectomy, renal calculus, hypernephroma, malignant tumors of the bladder, cystoscopy, and pelography.

ST. MARY'S HOSPITAL

Tuesday

James A. Kelly—9. General surgery.
William J. Ryan—9. General surgery.
Wilbur H. Haines and L. F. Milliken—2. Genito-urinary clinic.
W. T. Rees. Laboratory demonstration.

Wednesday

William A. Steel—9. Abdominal surgery with spinal anæsthesia.
A. P. Keegan—9. General surgery and local anæsthesia.
C. Howard Moore—2. Orthopedic clinic, operations and demonstration of cases.
W. T. Rees. Laboratory demonstration.

Thursday

Frank D. Harris—9. Gynecology.
William F. Morrison—9. Gynecology.
William E. Parke and J. Stuart Lawrence—12:30. Obstetrical clinic, labor room and ward walks. Operations. Prenatal clinic.
W. T. Rees. Laboratory demonstration.

MEDICO-CHIRURGICAL HOSPITAL

Tuesday

J. B. Carnett—9. General surgery.
George M. Boyd—11. Gynecology.

Wednesday

George W. Outerbridge—9. Cystoscopy.
William R. Nicholson—9. Gynecology.

Friday

J. B. Carnett—9. General surgery.
George M. Boyd—11. Gynecology.

PENNSYLVANIA HOSPITAL

Tuesday

Charles F. Mitchell, W. Estell Lee, Henry P. Brown, and Leon Herman—11. General surgery.

Wednesday

John H. Gibbon, Arthur E. Billings, Edward J. Klopp, John B. Flick, and Leon Herman—11. General surgery.

Thursday

James Cameron—9. Oral surgery.
J. R. Paul—10. Surgical pathology.
Charles F. Mitchell, W. Estell Lee, Henry P. Brown, and Leon Herman—11. General surgery.

POLYCLINIC HOSPITAL

Tuesday

DeForest P. Willard—10:30. Orthopedics.
G. E. Pfahler—2. Radiologic conference.
B. A. Thomas—2. Urology.

Wednesday

R. H. Ivy and Lawrence Curtis—10. Oral surgery.
W. G. Elmer—11:30. Orthopedic surgery.

Thursday

Collier F. Martin—1. Proctology.
J. F. Schamberg—2. Arsphenamin clinic.

Friday

R. H. Ivy—9. Maxillofacial surgery.
B. A. Thomas—2. Urology.
E. A. Case—2. Surgical pathology.

ST. AGNES HOSPITAL

Tuesday

E. C. Murphy—9. Dry clinic: Exhibition of fracture cases with end-results by operative and non-operative procedures.
John F. X. Jones—9. General surgery, operative clinic.
John A. McGlinn—9. Gynecology. Exhibition of patients treated for acute inflammatory diseases by means of nonspecific proteins. Demonstration of method of treatment of gonorrhœa in the female by heat.

Wednesday

G. M. Dorrance and J. W. Bransfield—9. Operative clinic and demonstration of cases. Cleft palate cases operated on by the new method, elongation of palate.
John M. Fisher—9. Gynecology.
Wilbur B. Haines—2. Genito-urinary surgery.
J. C. Hirst and staff—2. Gynecology and obstetrics.

NORTHEASTERN HOSPITAL

Wednesday

H. Z. Hibshman—9. Anorectal infections.
T. Turner Thomas—10. General surgery.
John B. Lownes and J. A. Broadfield—3. Operative and cystoscopic clinic.

Thursday

T. Turner Thomas—2. Dry clinic: Results with non-operative reduction, especially of wrist, elbow, shoulder, hip, and ankle. Operative reductions. Compound fractures. Recurrent dislocations of shoulder. Brachial birth palsy.

UNIVERSITY HOSPITAL

Tuesday

John G. Clark, C. C. Norris, and F. E. Keene—9. Gynecology.
C. H. Frazier, F. Grant, and Temple Fay—9. Neurosurgery.
B. C. Hirst, E. B. Piper, J. C. Hirst, II, J. K. Jaffe, G. V. Janvier, and W. Benson Harer—9. Obstetrics and gynecology.
George P. Muller and I. S. Ravdin—9. General surgery.
A. Bruce Gill—9. Orthopedics.
Chevalier Jackson and Gabriel Tucker—3. Bronchoscopy.

Wednesday

John G. Clark, C. C. Norris, and F. E. Keene—9. Gynecology.
E. L. Eliason and Drury Hinton—9. General surgery.
A. Randall, S. W. Moorhead, P. S. Pelouze, and Maurice Muschat—2. Urology.

Thursday

John G. Clark, C. C. Norris, and F. E. Keene—9. Gynecology.
C. H. Frazier, F. Grant, and Temple Fay—9. Neurosurgery.
B. C. Hirst, E. B. Piper, J. C. Hirst, II, J. K. Jaffe, G. V. Janvier, and W. B. Harer—9. Obstetrics and gynecology.
G. P. Muller and I. S. Ravdin—9. General surgery.
A. Bruce Gill—9. Orthopedics.
Chevalier Jackson and Gabriel Tucker—3. Bronchoscopy.

Friday

John G. Clark, C. C. Norris, and F. E. Keene—9. Gynecology.
C. H. Frazier, F. Grant, and Temple Fay—9. Neurosurgery.
B. C. Hirst, E. B. Piper, J. C. Hirst, II, J. K. Jaffe, G. V. Janvier, and W. B. Harer—9. Gynecology and obstetrics.
E. L. Eliason and Drury Hinton—9. General surgery.
A. Bruce Gill—9. Orthopedics.

CHESTNUT HILL HOSPITAL

Tuesday

Andrew Godfrey and William Sheehan—10. General surgery.
Alexander Randall—2. Urology.

Wednesday

J. Murray Ellzey—10. Fracture clinic.

Thursday

J. F. McCloskey—10. General surgery.

KENSINGTON HOSPITAL FOR WOMEN

Tuesday

William E. Parke—11. Prenatal clinic, history taking, pelvimetry, blood-pressure records, obstetrical analgesia.
H. C. Deaver—12:30. General surgical clinic.

Friday

Daniel Longaker—11. Potter version statistics and demonstration of available material.

PHILADELPHIA GENERAL HOSPITAL

Tuesday

FRANK C. HAMMOND—10. Gynecological operations.
WILLIAM H. MACKINNEY—2. Genito-urinary operations.

Wednesday

ALFRED C. WOOD—9. General surgery.
J. T. RUGH—11. Orthopedic surgery.
STAFF—2. Symposium on Cancer: J. B. CARNETT, general surgery; HENRY K. PANCOAST, radiology; C. C. NORRIS, gynecology; J. F. SCHAMBERG, dermatology; ROBERT G. TORREY, medical; GEORGE M. DORRANCE, faciomaxillary; F. O. LEWIS, laryngology. Visit to radium emanation plant and deep therapy laboratories.

Thursday

J. B. CARNETT, J. RALSTON WELLS, ROBERT BRADLEY and JAMES P. WEATHERWAX—9. Nonoperative cancer clinic.
EDWARD A. SCHUMANN—2. Gynecological operations.

Friday

T. T. THOMAS—9. General surgery.
C. C. NORRIS—11. Gynecological clinic, cancer operations.
EDWARD B. KRUMBHAAR and staff of pathologists—4. Clinicopathological conference, demonstrating current interesting pathological conditions and specimens. Open discussion is invited at this conference.

MISERICORDIA HOSPITAL

Tuesday

BASIL BELTRAN and staff—9. General surgery.
JAMES A. KELLY and staff—9. General surgery.

Wednesday

GEORGE P. MULLER and THOMAS RYAN—9. General surgery.
PETER M. KEATING—9. Clinical demonstration.
J. F. X. JONES—2. General surgery.

Thursday

BASIL BELTRAN and staff—9. General surgery.
JAMES A. KELLY and staff—9. General surgery.

Friday

GEORGE P. MULLER and THOMAS RYAN—9. General surgery.
PETER M. KEATING—9. Clinical demonstration.
J. F. X. JONES—2. General surgery.

NORTHWESTERN GENERAL HOSPITAL

Tuesday

J. O. ARNOLD—2. Obstetrical clinic. Perineotomy, an improved technique.

Wednesday

J. T. SCHELL—9. General surgery.

Thursday

ARTHUR D. KURTZ—3:30. Orthopedic dry clinic.

Friday

ROBERT BOYER—11. Genito-urinary clinic. Suprapubic prostatectomy.

LANKENAU HOSPITAL

Tuesday

STANLEY P. REIMAN—9. Demonstrations in new laboratory.
A. G. MILLER, and ROBERT SHOEMAKER—11. Demonstration in roentgenology.
F. L. HARTMAN—11. Demonstration of follow-up system.

Wednesday

STANLEY P. REIMAN—9. Demonstration in new laboratory.
F. L. HARTMAN—11. Demonstration of follow-up system.
A. G. MILLER and ROBERT SHOEMAKER—11. Demonstration in roentgenology.
JOHN B. DEAVER—12. General surgery.

Thursday

F. L. HARTMAN—11. Demonstration of follow-up system.
A. G. MILLER and ROBERT SHOEMAKER—11. Demonstration in roentgenology.
JOHN B. DEAVER—12. General surgery.
WILLIAM H. MACKINNEY—5:30. Cystoscopy.

Friday

STANLEY P. REIMAN—9. Demonstration in new laboratory.
A. G. MILLER and ROBERT SHOEMAKER—11. Demonstration in roentgenology.
F. L. HARTMAN—11. Demonstration of follow-up system.

ST. JOSEPH'S HOSPITAL

Tuesday

JOSEPH M. SPELLISSY—9. Dry clinic: Operative mechanical treatment of some of the effects of infantile paralysis.
JOHN F. X. JONES—11. General surgery; appendectomy, gall-bladder disease.

Wednesday

MELVIN M. FRANKLIN—9. General surgery; influence of prosthetics upon amputations; chronic, nontuberculous suppuration in bone.
F. HURST MAIER—11. Gynecology; hysterectomy for myofibromata, plastic for procidentia, suspension for retroflexion.

Thursday

JAMES A. KELLY—9. General surgery; fracture clinic.

Friday

CHARLES F. NASSAU—9. General surgery; subtotal thyroidectomy under local anæsthesia, hernioplasty under local anæsthesia.
P. BROOKE BLAND—11. Gynecology; application of radium for uterine myofibromata, trachelorrhaphy and perineorrhaphy, abdominal hysterectomy.

WOMAN'S COLLEGE HOSPITAL

Tuesday

LIDA STEWART-COGILL—9. Prenatal clinic.

Wednesday

J. S. RODMAN and STAFF—9. General surgery.

Thursday

CATHARINE MACFARLANE—2. Gynecology.

Friday

J. S. RODMAN and STAFF—9. General surgery.

HAHNEMANN HOSPITAL

Tuesday

L. T. Ashcraft, William C. Hunsicker, Frank C. Benson, Jr.—9. Urologic clinic. Symposium on tumors of the urinary bladder and on carcinoma of the prostate. Demonstration of local anæsthesia.

J. E. James, Jr., and Leon Clemmer—10. Obstetrical clinic. Salient points in pelvimetry. The rôle of version in obstetrical surgery. Cervico-abdominal hysterectomy.

F. W. Smith—2. Bronchoscopic work on the cadaver.

F. C. Benson, Jr.—3. Radium clinic. Technique of application and results in superficial malignant tumors. Limitations, contra-indications, and dangers in radium therapy.

Wednesday

H. L. Northrop—9. Thoracic surgery.

D. B. James and E. B. Craig—9. Gynecological clinic. Malignancy of the uterus.

W. C. Mercer and J. B. Bert—10. Obstetrical clinic. Forceps application with special reference to the cephalic application in posterior oblique positions The mechanism of labor.

S. W. Sappington—3. Demonstration of various methods of blood transfusion.

Thursday

J. D. Elliott and William M. Sylvis—9. Operative clinic. Tumors of the breast. Discussion of the pathology and end-results of treatment by X-rays, radium, and operation.

D. B. James—9. Gynecological clinic.

O. B. Waite and N. F. Paxson—10. Obstetrical clinic. Prenatal care. Practical results of routine Wassermann tests. Pre-eclampsia and eclampsia. Fetal mortality.

J. A. Brooke—2. Orthopedic clinic. Shortening of bones of the leg to correct inequality in length. Demonstration of new bone skid. Results of astragalectomy in paralytic foot.

J. W. Frank—3. Roentgenologic clinic. Comparison of newer forms of roentgen treatment for malignancy with former methods. Presentation of patients.

Friday

G. A. Van Lennep and H. P. Leopold—9. Surgery of the stomach and duodenum.

N. F. Lane and D. W. Culin—9. Uterine bleeding, diagnosis and treatment.

SAMARITAN HOSPITAL

Tuesday

John Leedom, J. O. Bower, G. Mason Astley, John C. Frick, and J. N. Coombs—9. Surgical clinic.

Harry Hudson—2. Orthopedic clinic.

Albert Strickler—3. Dermatology.

Wednesday

W. Wayne Babcock—9. General surgery.

Charles S. Barnes and C. M. Stimson—11. Obstetrics.

Frank C. Hammond—2. Gynecology.

W. Hershey Thomas—4. Genito-urinary surgery.

Harry Z. Hibshman—5. Rectal clinic.

Thursday

A. C. Applegate—11. Obstetrics.

Friday

W. Wayne Babcock—9. General surgery.

CHILDREN'S HOSPITAL

Tuesday

J. H. Jopson—9. Diagnosis in surgical diseases of the abdomen.

J. C. Gittings—9. Some medical aspects of surgical cases.

C. W. Burr and F. E. Leavitt—9. Neurosurgical problems in children.

C. C. Norris—2. Vaginitis in infants and young children; methods of treatment.

Wednesday

W. Estell Lee and J. R. Wells—9. Problems in thoracic surgery. Treatment of burns.

R. S. Bromer—9. X-ray in thoracic and gastro-intestinal lesions.

Thursday

Howard C. Carpenter—9. Health examination in children.

Emily P. Bacon—9. Demonstration of nutritional work in children.

Susan C. Francis, R. N.—9. Problems in management of surgical wards.

Friday

John Speese and W. Edgar Christie—9. Postoperative management of surgical cases.

Henry P. Brown and Ernest G. Williamson—9. Management of the surgical out-patient department.

MT. SINAI HOSPITAL

Tuesday

Charles F. Nassau—9. Radical cure of hernia, local anæsthesia.

G. Rosenbaum—12. X-rays of gastro-intestinal tract.

Wednesday

M. Behrend—9. Surgery of bile passageways and gastro-intestinal tract. Presentation of cases.

M. Cooperman—2. Gonorrhœal arthritis, dislocation of hip, astragalectomy, Whitman reconstruction operation.

G. Tucker—4. Bronchoscopy and œsophagoscopy.

Thursday

J. C. Hirst—9. Prolapse of uterus, cystoscopy, vaginal repair.

G. Rosenbaum—12. X-rays of gastro-intestinal tract.

G. Tucker—4. Bronchoscopy and œsophagoscopy.

Friday

C. Mazer—9. Plastic, Rubin test, and pyelography.

C. Hirsh—11:30. Demonstration of cases.

FRANKFORD HOSPITAL

Wednesday

W. E. Parke—9:30. Plastics, plastic and retroversion of uterus.

E. A. Schumann—9:30. Fibroid of uterus, carcinoma of uterus, plastic and section.

G. C. Hanna—9:30. Cæsarian section.

F. E. Keller—9:30. Cæsarian section, local anæsthesia.

Thursday

Charles F. Nassau—9:30. Cholelithiasis, duodenal ulcer, nephrolithiasis, goiter.

Louis D. Englerth—9:30. Hernia under local anæsthesia, fracture clinic.

WOMAN'S HOSPITAL

Tuesday

SARAH H. LOCKREY and EMILY WHITTEN-AUGE—9. Gynecology.
LIDA STEWART COGILL and ELIZABETH HUGHES—2. Obstetrics.
JULIA HARDIN—Gas oxygen and ethylene anæsthesia.

Wednesday

MARIE K. FORMAD and ALBERTA PELTZ—9. Gynecology.
ELLA WILLIAMS GRIM and ALBERTA PELTZ—3. Obstetrics.
JULIA HARDIN—Gas-oxygen and ethlene anæsthesia.

Thursday

CATHARINE MACFARLANE and FAITH S. FETTERMAN—9. Gynecology.
MARY LEWIS and DELLA MILDAZIAS—3. Obstetrics.
JULIA HARDIN. Gas-oxygen and ethylene anæsthesia.

Friday

KATE W. BALDWIN—9. General surgery.
ELIZABETH F. C. CLARK—11. Gynecology.
ANN TOMKINS GIBSON and JESSIE W. PRYOR—2. Obstetrics.
EMILY WHITTEN-AUGE—3. General surgery.
JULIA HARDIN. Gas-oxygen and ethylene anæsthesia.

STETSON HOSPITAL

Tuesday

JOHN A. BOGER and WILLIAM T. ELLIS—1. General surgery.

Wednesday

S. E. TRACY and Associates—9. Gynecology.

Thursday

BROOKE M. ANSPACH and Associates—9. Gynecology.

Friday

S. E. TRACY and Associates—9. Gynecology.
CARL F. KOENIG—1. Roentgenology.

CHILDREN'S HOMEOPATHIC HOSPITAL

Tuesday

H. P. LEOPOLD—2. General surgery.

Wednesday

JOHN BROOKE—2. Orthopedic clinic: After-results in epiphyseal fractures; club hand; syphilitic joints; joint changes in endocrine disturbances.

Thursday

A. KORNDOERFER, JR.—2. Obstetrical clinic.

AMERICAN ONCOLOGIC HOSPITAL

Tuesday

W. S. NEWCOMET—10. Cases of angioma, treated and under treatment, selected from a group of 200.
SAMUEL MCCLARY, III.—10. Cases of cancer of the lip and mouth.

ST. CHRISTOPHER'S HOSPITAL

Tuesday

E. G. ALEXANDER—10. Surgical clinic: hernia, appendix, pyloric stenosis, undescended testicle, hare lip, empyema, and bone cases. Surgery in children.

HOWARD HOSPITAL

Tuesday

A. C. WOOD—9. General surgery.
E. L. ELIASON, DRURY HINTON, and V. W. M. WRIGHT—10:30. General surgery. Industrial surgery clinic. Outline of system of records, follow-up. Routine surgery.

Wednesday

B. C. HIRST—9. Gynecology.

Thursday

A. C. WOOD—9. General surgery.
E. L. ELIASON, DRURY HINTON, and V. W. M. WRIGHT—10:30. Fracture clinic, methods and results.
E. L. ELIASON—11. Routine surgery under local anæsthesia.
S. W. MOORHEAD—4. Genito-urinary clinic.

Friday

B. C. HIRST—9. Gynecology.

PRESBYTERIAN HOSPITAL

J. H. JOPSON, JOHN SPEESE, D. B. PFEIFFER, J. S. RODMAN, and HENRY P. BROWN, JR. General surgery.
JOHN H. GIRVIN, GEORGE M. LAWS, and PHILIP WILLIAMS. Gynecology.
B. A. THOMAS and STAFF. Genito-urinary surgery.
A. BRUCE GILL and T. E. ORR. Orthopedic surgery.
FRANK CROZER KNOWLES and HENRY G. MUNSON. Dermatology.
JOHN A. EIMAN and W. EDGAR CHRISTIE; JOHN H. GIRVIN and staff; B. A. THOMAS and F. G. HARRISON. Surgical and special pathology.
WILLIAM S. NEWCOMET. Roentgenology.
Operative clinics daily at 9. Demonstrations and pathological exhibits in new out-patient and laboratory building at 2:30.

JEWISH HOSPITAL

Tuesday

M. BEHREND—9. General surgery.
W. H. TELLER—2. General surgery.

Wednesday

F. B. BLOCK—9. General surgery.
L. BRINKMAN—2. General surgery.

Thursday

M. BEHREND—9. General surgery.
F. B. BLOCK—2. General surgery.

Friday

L. BRINKMAN—9. General surgery.
W. H. TELLER—2. General surgery.

WOMEN'S HOMEOPATHIC HOSPITAL

Tuesday

JOHN A. BROOKE—2. Orthopedics.

Wednesday

ARTHUR HARTLEY—2. General surgery.

Friday

FRANCOIS L. HUGHES—10. Gynecology.

COOPER HOSPITAL (Camden)

Tuesday

THOMAS B. LEE, ALBERT B. DAVIS, and GORDON WEST—9. Gynecology.

Wednesday

PAUL M. MECRAY and Associates—10. General surgery.
A. HAINES LIPPINCOTT and DAVID BENTLEY, JR.—2:30. Genito-urinary and rectal clinic.
B. F. BUZBY—2:30. Orthopedic clinic.

Thursday

THOMAS B. LEE, ALBERT B. DAVIS, and GORDON WEST—9. Gynecology.

Friday

PAUL M. MECRAY and Associates—10. General surgery.
B. F. BUZBY—2:30. Orthopedics.

ST. LUKE'S HOSPITAL

Tuesday

DESIDERIO ROMAN—9. General surgery.
O. F. BARTHMAIER—11. Demonstration of blood transfusion.

Wednesday

A. B. WEBSTER—9. General surgery.
J. WALTER POST—11. Demonstration in roentgenology.

Thursday

DESIDERIO ROMAN—9. Operations upon thyroid and demonstration of group study of thyroid disease.

Friday

A. B. WEBSTER—9. General surgery.
J. WALTER POST—11. Demonstration in roentgenology.

SURGERY OF THE EYE, EAR, NOSE, AND THROAT

CLINICAL DEMONSTRATIONS

In the Ballroom, Bellevue-Stratford

Tuesday—9 A.M.

BEN WITT KEY, New York City: Foreign protein therapy, experimental and clinical.

JOSEPH C. BECK, Chicago: Management of some of the important complications from ear, nose, and throat diseases and operations.

WELLS P. EAGLETON, Newark, N. J.: Meningitis of aural origin.

Wednesday—9 A.M.

CHEVALIER JACKSON, Philadelphia: Laryngofissure for cancer of the larynx.

HARRY S. GRADLE, Chicago: Practical use of the slit lamp in daily routine.

DOUGLAS QUICK, New York City: Use of radium and X-ray in the treatment of malignant disease of the paranasal sinuses.

JOHN E. MACKENTY, New York City: Laryngectomy in one stage, comments on one hundred operations.

Thursday—9 A.M.

PROFESSOR F. NAGER, Zurich, Switzerland: Otology.

E. C. ELLETT, Memphis, Tenn.: Use of the suture in cataract extraction.

GEORGE E. SHAMBAUGH, Chicago. Otology.

T. E. CARMODY, Denver, Colo. Observations on children's sinuses in health and diseases.

Friday—9 A.M.

MAJOR EDMUND B. SPAETH, Takoma Park, Md.: Ophthalmic plastic surgery, illustrated with lantern slides.

GEORGE M. DORRANCE, Philadelphia: Rhinoplasty, presentation of cases, lantern slide demonstration.

WARREN B. DAVIS, Philadelphia: Some types of harelip and cleft palate deformities and their operative results.

EPISCOPAL HOSPITAL

Tuesday

W. R. WATSON, EDWARD W. COLLINS, and OTTO C. HIRST—2. Otolaryngology.
HAROLD G. GOLDBERG, DAVID J. BOONE, and WILLIAM H. CHANDLEE—2. Ophthalmology.

Wednesday

A. G. FEWELL, WARREN S. REESE, J. B. RUDOLPHY, and FRED HERBERT, JR.—2. Ophthalmology.
W. R. WATSON and Associates—2. Otolaryngology.

Thursday

FREDERICK KRAUSS and J. B. FELDMAN—2. Ophthalmology.
CHARLES C. BIEDERT, THOMAS R. CURRIE, and WILLIAM MATTHEWS—2. Otolaryngology.

Friday

CHARLES C. BIEDERT and Associates—2. Otolaryngology.
HAROLD G. GOLDBERG and Associates—2. Ophthalmology.

HOWARD HOSPITAL

Tuesday

G. B. WOOD—2. Laryngology.

Wednesday

W. C. POSEY—2. Ophthalmology; varied eye operations.

Thursday

G. B. WOOD—2. Laryngology.

Friday

W. C. POSEY—2. Ophthalmology.

ST. MARY'S HOSPITAL

Tuesday

FRANK MURPHY—2. Eye clinic.

Wednesday

EDWARD MURPHY, WILLIAM P. GRADY, and ALBERT J. DEVLIN—3. Otolaryngology.

WILLS EYE HOSPITAL

Tuesday

BURTON CHANCE, FRANK C. PARKER, LEIGHTON F. APPLEMAN, and BENJAMIN F. BAER, JR.—2. Ophthalmic operations.

Wednesday

WILLIAM ZENTMAYER, PAUL J. PONTIUS, J. MILTON GRISCOM, and THOMAS A. O'BRIEN—2. Ophthalmic operations.

Thursday

BURTON CHANCE, FRANK C. PARKER, LEIGHTON F. APPLEMAN, and BENJAMIN F. BAER, JR.—2. Ophthalmic operations.

Friday

WILLIAM ZENTMAYER, PAUL J. PONTIUS, J. MILTON GRISCOM and THOMAS A. O'BRIEN—2. Ophthalmic operations.

ST. JOSEPH'S HOSPITAL

Tuesday

GEORGE M. MARSHALL—2. Otolaryngology; osteoplastic correction of the nasal bones, radical maxillary sinus operation.

PAUL J. PONTIUS—2. Ophthalmology; enucleation with gold ball insertion, iridectomy.

Wednesday

CHARLES J. JONES—2. Ophthalmology; preliminary iridectomy for cataract, simple extraction.

WILLIAM E. QUICKSALL—2. Otolaryngology; tonsillectomy by Fetterolf's method, submucous resection.

Thursday

THOMAS A. O'BRIEN—2. Ophthalmology; combined extraction, Elliott trephine for glaucoma.

ARTHUR WRIGLEY—2. Otolaryngology; replacement of laterally displaced tip of quadrangular cartilage with submucous resection, tonsillectomy by decapsulation with dissection and snare.

CORNELIUS T. MCCARTHY—2. Otolaryngology; radical mastoidectomy, ethmoidectomy.

MEDICO-CHIRURGICAL HOSPITAL

Tuesday

GEORGE M. COATES—2. Otolaryngology.

Wednesday

ROSS H. SKILLERN—2. Laryngology.

Thursday

GEORGE M. COATES—2. Otolaryngology.

Friday

ROSS H. SKILLERN—2. Laryngology.

WOMAN'S COLLEGE HOSPITAL

Tuesday

MARGARET F. BUTLER—2. Otolaryngology.

Friday

MARY BUCHANAN—3. Ophthalmology.

JEWISH HOSPITAL

Wednesday

J. KNIPE—3. Eye clinic.

Thursday

S. MCC. SMITH and A. S. KAUFMAN—3. Otological clinic.

H. M. GODDARD—4. Nose and throat clinic.

FRANKFORD HOSPITAL

Tuesday

FRANK EMBERY—9:30. Tonsil and mastoid clinic.

W. J. WATSON—9:30. Tonsil clinic.

UNIVERSITY HOSPITAL

Tuesday

THOMAS B. HOLLOWAY—2. Ophthalmology.

G. FETTEROLF, J. A. BABBITT, D. HUSIK, and LEWIS FISHER—3. Otolaryngology.

Wednesday

G. FETTEROLF, J. A. BABBITT, D. HUSIK, and L. FISHER—3. Otolaryngology.

Thursday

THOMAS B. HOLLOWAY—2. Ophthalmology.

Friday

THOMAS B. HOLLOWAY—2. Ophthalmology.

GEORGE FETTEROLF, J. A. BABBITT, DAVID HUSIK, and LEWIS FISHER—3. Otolaryngology.

MISERICORDIA HOSPITAL

Tuesday

JOHN E. LOFTUS—2. Otolaryngology.

Wednesday

C. T. MCCARTHY—2. Otolaryngology.

HAROLD GOLDBERG—3. Ophthalmology.

Thursday

JOHN E. LOFTUS—2. Otolaryngology.

JOHN A. COLGAN—3. Opthalmology.

Friday

C. T. MCCARTHY—2. Otolaryngology.

POLYCLINIC HOSPITAL

Tuesday

T. B. HOLLOWAY—2. Ophthalmology.

Wednesday

WALTER ROBERTS—2. Otolaryngology.

E. B. GLEASON—3. Otolaryngology.

L. C. PETER—3. Ophthalmology.

Thursday

GEORGE B. WOOD—3. Laryngology.

RALPH BUTLER—3. Laryngology.

HAHNEMANN HOSPITAL

Tuesday

G. J. PALEN—2. Résumé of mastoid operation by otological department.

Thursday

H. S. WEAVER and C. B. HOLLIS—2. Nose and throat clinic.

Friday

F. O. NAGLE—2. Eye clinic. Pathology of the eye.

ST. AGNES HOSPITAL

Tuesday

BENJAMIN D. PARISH—2. Otolaryngology.

Wednesday

WARREN B. DAVIS—2. Otolaryngology.

GEORGE F. J. KELLY—2. Ophthalmology.

METHODIST EPISCOPAL HOSPITAL

Tuesday

WALTER ROBERTS—2. Deviated septum, tonsillectomies and adenoidectomies, mastoid disease and malignant disease of the larynx, bronchoscopy.

PHILIP H. MOORE—4. Enucleation, foreign body in the eye, strabismus, glaucoma.

JEFFERSON HOSPITAL

Thursday

Fielding O. Lewis—2. Otolaryngology.

Friday

Howard F. Hansell and William M. Sweet—2. Ophthalmology.
S. MacCuen Smith and J. Clarence Keeler—2. Otology.

COOPER HOSPITAL (Camden)

Tuesday

L. B. Hirst, E. R. Hirst, and Alfred Elwell—2:30. Otolaryngology.

Thursday

L. B. Hirst, E. R. Hirst, and Alfred Elwell—2:30. Otolaryngology.

WOMAN'S HOSPITAL

Tuesday

Laura E. Hunt and Mary Hipple—2. Otolaryngology.

Wednesday

Margaret A. Warlow—1:30. Otolaryngology.
Mary Buchanan—2. Ophthalmology.

Thursday

Margaret F. Butler and Louis van Loon—2. Otolaryngology.

SAMARITAN HOSPITAL

Luther C. Peter—Tuesday, 4. Ophthalmology.

CHILDREN'S HOMEOPATHIC HOSPITAL

Fred W. Smith—Tuesday, 2. Laryngological clinic, hypertrophied tonsils and adenoids.

STETSON HOSPITAL

Carle L. Felt and Associates—Wednesday, 1. Otolaryngology.

MT. SINAI HOSPITAL

Tuesday

L. Fisher—2. Tonsil and sinus surgery. Bárány test.
C. W. LeFever—4. Cataract, glaucoma, muscle work.

Thursday

S. J. Gittelson—2. Demonstration of cases.

Friday

A. W. Watson—2. Mastoid and tonsil surgery.

CHESTNUT HILL HOSPITAL

Wednesday

Benjamin Parish and John Davies—2. Otolaryngology.

Thursday.

Carl Williams—2. Ophthalmology.

CHILDREN'S HOSPITAL

Wednesday

H. Maxwell Landon and A. R. Renninger—2. Ophthalmology.

Thursday

James A. Babbitt and Staff—2. Otolaryngology.

PRESBYTERIAN HOSPITAL

H. Maxwell Langdon and Staff. Ophthalmology.
N. P. Stauffer and Staff. Otolaryngology.

NORTHEASTERN HOSPITAL

Wednesday

George E. Shaffer—2. Caldwell-Luc operation.
Granville A. Lawrence—4. Ophthalmology.

WOMEN'S HOMEOPATHIC HOSPITAL

Joseph F. V. Clay—Thursday, 2. Otolaryngology.

PHILADELPHIA GENERAL HOSPITAL

David N. Husik—Friday, 2. Otolaryngological operations.

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